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**Help-seeking within mental health services for individuals
with a history of chronic psychosis.**

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Doctorate in Clinical Psychology

The University of Edinburgh

August 2013

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Thesis Abstract

Help-seeking within mental health services for individuals with a history of chronic psychosis.

Background. Help-seeking is a concept of growing interest in the context of psychosis and the move towards early intervention and community-based service models. Despite a preponderance of first episode studies in this field, help-seeking is also of clinical relevance to adults with more chronic psychosis in the face of spiralling patterns of relapse and diminished recovery. Recent research into attachment theory opens up new avenues for exploring aspects of relating in psychosis, including help-seeking in mental health service contexts.

Methods. A systematic review of attachment and psychosis was carried out to critically assess the strength and nature of empirical support for this theory within a clinical context. A social-constructivist based grounded theory study of help-seeking and chronic psychosis was conducted amongst nine individuals in a long term rehabilitation service. This aimed to develop an experiential account and grounded theory of the processes shaping help-seeking for this clinical group. Study findings were reviewed against existing constructs of attachment style, service attachment, recovery style and beliefs about psychosis.

Results. A grounded theory emerged from the study emphasising the importance of three domains; ‘beliefs about the self’, ‘beliefs about others’ and ‘service experience’, in dynamically shaping views to help-seeking and receiving, for those with chronic psychosis. Attachment theory and recovery coping style were seen as compatible with this model.

Conclusions. Individuals with chronic psychosis may continue to experience difficulties with help-seeking and service engagement, even within supported service settings. An appreciation of the interpersonal significance of service interactions, and improved understanding in this area, may help services better anticipate, respond to and adjust their models of engaging for this important clinical group.

Systematic Literature Review

How does adult attachment organisation in adults with psychosis relate to the presentation of psychosis-related symptoms, interpersonal functioning and service engagement within a clinical population ? A systematic review.

Abstract

Background: Attachment theory is of growing interest in the context of psychosis-related disorders, although empirical support has often been drawn from general psychopathology or analogue studies. This review adds to the current literature by systematically and critically appraising the clinical evidence base in this field.

Method: A systematic search of the literature was performed via ASSIA, Medline, EMBASE, CINAHL-Plus, PsychINFO and the Cochrane databases, using the string ‘attachment’ AND [‘psychosis’ OR ‘schizophrenia’]. Searches were limited to the English language. Study quality was assessed using a tailored critical appraisal checklist adapted from the Critical Appraisal Skills Programme framework.

Results: Eighteen studies met inclusion criteria. The review supported an association between insecure patterns of adult attachment and psychosis, particularly avoidant style organisations. Relationship with symptoms was less coherent, suggestive of a more complex pathway mediating this relationship. Findings were consistent with the view that service support can function as attachment relationships.

Conclusions: Attachment theory can offer a useful framework for developing hypotheses regarding the presentation of psychosis-related symptoms and factors influencing service engagement. However, there remains a demand for more in-depth, longitudinal studies with this population.

Keywords: Psychosis, schizophrenia, adult attachment, service engagement.

(Prepared for submission to the journal ‘Clinical Psychology Review’. Please note tables have been included in the text in line with university rather than journal requirements).

Highlights

- The clinical literature largely validates an association between insecure patterns of adult attachment and the presentation of symptoms of psychosis, particularly for avoidant-related organisations.
- Patient relationships with professionals can act as attachment relationships, thus eliciting the same type of interpersonal responses as other significant relationships, albeit to a potentially lesser magnitude.
- The relationship between adult patterns of attachment and psychosis-related phenomena remains unclear from the current clinical literature. This may be suggestive of an indirect, mediated pathway between these variables, which requires more sophisticated investigation.

Introduction

Attachment theory was originally formulated within the context of the infant-caregiver relationship, highlighting the evolutionary advantage of infants forming a consistent and stabilising bond in order to establish a secure and protective base from which they can explore their environment (Bowlby, 1980). These early experiences underpin the development and internalisation of representational models of the self, personal capabilities and the world, forming a template for future interpersonal functioning across the lifespan (Bowlby, 1982). Whilst the continuity of specific patterns of infant attachment into adulthood remains debatable (*see* Goodwin, 2003), it is generally agreed that significant adult relationships may take on the quality of an attachment relationship, reflecting internal working models of the self as being worthy or unworthy of affection, and others as being able, or incapable, of meeting attachment needs (Ainsworth, 1991; Ma, 2006),

Interest in the significance between adult mental health and the loss of an early parental bond, spans over sixty years (Goodwin, 2003). Indeed much of the inspiration for attachment theory was based on observations made within a clinically disordered population (Fonagy *et al.*, 1996; Ma, 2006). However, it is only within the past two decades or so that the growing research interest in attachment has extended to adult clinical populations, and early findings indicating an over-representation of insecure patterns amongst this group has encouraged further exploration into pathways between psychopathology and attachment in this field (*e.g.*, Dozier, 1990, 1991, Dozier & Lee, 1995; Goodwin, 2003; Ma, 2006; Mason, Platts & Tyson, 2005; van IJzendoorn & Bakermans-Kranenburg, 1996).

Attachment and pathways to psychopathology

Goodwin (2003) highlights three, non-mutually exclusive ways in which attachment-related phenomena may negatively impact on mental health. Firstly, the distress and loss caused by the rupture of a significant attachment bond may, in itself, be sufficient to cause a long term disturbance in mental health. Secondly, disrupted attachment may lead to the internalisation of working models which hinder an

individual's ability to form protective relationships, leaving them vulnerable to further attack or distress. Finally, attachment states of mind may influence the way an individual interprets, responds to and uses current interpersonal relationships, again increasing their vulnerability to stress in adulthood.

There is growing consolidation of evidence in the literature for the significance of early adverse, interpersonal experiences associated with the disruption of attachment, and the later development of psychopathology (e.g. Mickelson, Kessler & Shaver, 1997; Varese *et al.* 2012). However, not all individuals with traumatic histories go on to develop mental health problems (Jones, 1996) suggesting this is unlikely to be a direct pathway. A number of additional mediating factors have been hypothesised to play a role in increasing vulnerability to clinical level disorder (Platts, Tyson & Mason, 2002). Examples include the role of emotion regulation strategies (Sroufe, Dugga, Weingfield & Carlson, 2000), cognitive schemas (Platts *et al.*, 2002) and reflective functioning (MacBeth, Gumley, Schwannauer & Fisher, 2011), and the interpersonal consequences of these.

Attachment and emotion regulation

Early experiences are hypothesised to play a key developmental role in the generation of potentially adaptive skills and capacities which can protect an individual from later stress and increased vulnerability to mental disorder in later life (Sroufe *et al.*, 2000). Those exposed to poor caregiver experiences and opportunities for secure attachment, may have had little opportunity to internalise adaptive strategies for the appropriate acknowledgement, expression and containment of intense emotions, with consequences for adulthood (Sroufe *et al.*, 2000; Cassidy, *as cited in* Mikulincer & Shaver, 2012; Mikulincer, Shaver & Pereg, 2003). A college study by Wei, Vogel, Ku & Zakalik (2005) found that the rigidity of strategies adopted for managing affect amongst individuals with insecure attachment could indeed lead to increased distress and social conflict. For example, the 'cutting off' of emotions used by avoidant-type individuals could offer initial protection from negative affect, but led to alienation from support networks and risked defences becoming overwhelmed. Likewise, the 'emotional reactivity' associated with anxious

attachment, secured initial attention but exhausted social networks, leading to spiralling, uncontained distress.

Attachment and social cognition

Difficult early experiences associated with insecure attachment, may also have a cognitive impact, preventing the development of a coherent, stable sense of 'self', and leading to the internalisation of a threatening or unreliable sense of 'other' (Platts *et al.*, 2002). This could promote destructive patterns of self-criticism, fragmentation of the self or the over-reliance on rigid defences (Bartholomew & Horowitz, 1991; Park, Crocker & Mickelson, 2004; Wei *et al.*, 2006). Fonagy *et al.* (1991, 1996) looked at the link between abusive early experiences, impairments in reflective functioning and the onset of mental disorder, hypothesising that the inhibition of mentalising function at a young age may serve a protective purpose, defending an individual from the potentially threatening content of others' intentions. However, an ongoing absence of reflective capacity in adulthood may have catastrophic consequences, increasing exposure to interpersonal disconnection and distress, and becoming a core feature of psychopathology (Fonagy *et al.*, 1996).

Attachment patterns in psychopathology

Much of the early epidemiological literature looking at the relationship between attachment and psychopathology attempted to identify high-level differences in attachment patterns between diagnostic categories. A controlled study by Fonagy *et al.* (1996) for example, demonstrated that childhood attachment narratives gathered on the AAI, were sufficiently differentiated so as to distinguish between clinical and non-clinical groups. They also found some significant variations particular to specific diagnostic groups, such as an increased prevalence of 'parental idealisation' elements in the narratives of those with an eating disorder. Similarly, a large scale review of over 10,000 AAI's carried out by Bakermans-Kranenburg and van IJzendoorn (2009) identified a significant over-representation of insecure and unresolved attachment patterns amongst clinical groups. They found a link between disorders with an internalising dimension (e.g. borderline personality disorder), and preoccupied and unresolved attachments, and externalising dimensions (e.g. antisocial personality

disorder) and dismissing and preoccupied attachment. Other studies have also detected similar diagnostic splits, finding associations between avoidant attachment and ‘distress-minimising’ conditions, such as substance misuse disorder (Rosenstein & Horowitz, 1996; Mickelson *et al.*, 1997) and preoccupied attachment and disorders with displays of high subjective distress, such as borderline or histrionic personality disorder (Fossati *et al.*, 2003; Patrick, Hobson, Castle, Howard & Maughan, 1994).

Attachment research at a disorder-specific level

Whilst a consideration of relational factors in the context of diagnostic categories has opened up fresh perspectives on the correlates of disorders, attempts to consolidate findings from such an approach have remained inconclusive (Mikulincer & Shaver, 2012; Morrison, Read & Turkington, 2005). Differences in diagnostic classification, co-morbidities and attachment assessment methodologies have prevented direct comparison of studies (Ma, 2006). Furthermore, influences between attachment and the onset of a disorder are likely to be dynamic and open to multiple interacting influences, including the way in which the onset of a disorder may in itself influence adult attachment states (Mikulincer & Shaver, 2012).

As a result, there is an argument for research to move onto more meticulous, focused studies offering more specific hypotheses and insights into the potential pathways of influence for attachment *within* the context of specific disorders (Read & Gumley, 2008). The role of attachment theory within the context of psychosis-related disorders has been one such area of growing interest and exploration.

Attachment and psychosis

Clinicians have long recognised the importance of past and current interpersonal adversity in psychosis, yet historically attachment theory has been given little attention in this field (Berry, Barrowclough & Wearden, 2007a). Instead, the biological medical model has dominated studies of schizophrenia, overshadowing the exploration of wider interpersonal and developmental contributing factors to psychosis (Bentall, 2003; Read & Gumley, 2008). However, a growing interest in attachment theory in general, and increased recognition of its synergy for clinical

presentations of psychosis, has acted as a valuable catalyst in prompting further research and debates in this field over the last fifteen years.

Many of the earlier findings in relation to attachment and psychosis were based on studies using general psychiatric populations, which included a subset of individuals with a schizophrenia-related diagnosis. A significant body of work by Dozier *et al.* (1990, 1991, 1999) validated the links between deactivating attachment strategies and the onset and course of psychosis. They also recognised a prevalence of disorganised-type attachment in individuals with schizophrenia (Dozier & Tyrrell, 1997) and a relationship between avoidant patterns of attachment and the under-reporting of symptoms (Dozier *et al.*, 1991). Such findings have played an important role in motivating further investigation into attachment and psychosis, and the need for a more detailed consideration of study design when assessing attachment with this population.

A further contribution to the study of psychosis and attachment has been generated amongst analogue, non-clinical populations, with a particular focus on exploring the hypothesis that attachment style may be associated with particular types of symptomatology. Whilst these studies have generally highlighted some association between insecure attachment, particularly avoidant style patterns, and schizotypal traits (Tiliopoulos & Goodall, 2009; Wilson & Costanzo, 1996; Berry *et al.*, 2006, 2007b, Pickering, Simpson & Bentall, 2008), the size and nature of this relationship has not been consistently identified. Berry *et al.* (2006, 2007b) for example, identified associations between attachment anxiety and cognitive disorganisation, and attachment avoidance and introverted anhedonia. They also discovered that attachment avoidance was a significant predictor of unusual experiences (*e.g.* anomalous experiences and magical thinking). Likewise, Berry *et al.* (2006) discovered links between avoidant styles of attachment and non-clinical paranoia. Pickering *et al.* (2008) also investigated the relationship between attachment, paranoid beliefs and hallucinatory experiences in a non-clinical sample, but only found a relationship between insecure attachment and paranoia, but not hallucinations. They showed that negative self esteem, anticipation of threatening

events and a perception of others as being powerful, mediated the relationship between attachment insecurity and persecutory paranoia.

Therefore, the contribution of analogue and general psychiatric studies has offered a useful starting point for stimulating hypotheses and empirical investigation for attachment and psychosis. However, there are a number of limitations to these studies. These include the small sample sizes and heterogeneity of clinical subsets from the general psychiatric studies, and the debatable representation offered by student analogue populations for issues relevant to actual sufferers of a disorder, particularly those with a chronic history of psychosis (Ma, 2006). Consequently, there remains some significant value in understanding the contribution that clinical studies have made to this field. This is not only in forming a more detailed and specific picture of the possible associations between patterns of attachment and psychosis-related phenomena, but also in acquiring a more dynamic view of the way in which attachment and features of a disorder may be of mutual influence within a clinical setting.

Interpersonal relationships in adults with psychosis

A final area which will be of focus in this review is the way in which adult attachment and interpersonal relationships may play a role in the experience of psychosis, both within and beyond a service context.

There is support for the idea that poor early attachment experiences can limit the acquisition of social skills, and cause serious disruption in interpersonal relationships into adulthood (Bartholomew & Horowitz, 1991). Interpersonal difficulties are frequently recognised as integral to clinical presentations of psychosis, yet this area has received surprisingly little specific attention (Berry *et al.*, 2007a). Social isolation, communication problems and disturbed peer relationships can be predictors of psychoses (Read & Gumley, 2008) and social and occupational dysfunction is widely accepted as a diagnostic indicator of 'schizophrenia' (Sroufe *et al.*, 2000). However, the significance of interpersonal deficits may at times be downplayed, dismissing them as negative symptoms such as social withdrawal (Read & Gumley,

2008). Sroufe *et al.* (2000) argues for the importance of relationships as being both a risk and an asset for a vulnerable individual, and that this extends beyond a consideration of the family relationships alone. For example, peer relationships can play a powerful role in an individual's developmental history and sense of their interpersonal self, especially during the crucial stage of adolescence. Read and Gumley (2008) also point out the impact that a lack of a peer group may have at this crucial time, when an individual may be experiencing negative, distorted thoughts about themselves which are exposed to little external corrective influence. Berry *et al.* (2007a) proposes that attachment theory can help to formulate and understand current interpersonal styles in the context of earlier interpersonal experiences. Furthermore, it can help to place patterns of relating within a meaningful context, being associated with strategies which may have served an adaptive purpose at other times in their life (Mallinckrodt, 2000).

Interpersonal functioning and engagement within psychiatric service settings.

Perhaps the area in which there has been most reflection to date regarding the importance of interpersonal relating and attachment within both the general psychopathology literature and studies specific to psychosis, is in relation to engagement within services. A review by Berry and Drake (2010) proposes that attachment theory emphasises the importance of significant interpersonal loss that can occur within the context of a person's illness, as well as placing responses to staff and services into context. Given the often traumatic experience of hospitalisation and symptom experience (Gumley & Schwannauer, 2006) the attachment system may be likely to be triggered for individuals entering services with the resulting hyperactivating or deactivating coping strategies needing to be understood and responded to sensitively by staff teams.

The concept of staff as attachment figures has gained support within the literature (e.g. Ma, 2006; Bowlby 1988; Adshead, 1998, Goodwin, 2003), although there remains an acknowledged need for further empirical validation of this assumption. Furthermore, it is argued that attachment bonds may be formed at a service or institutional level, where the containing role of wards and routines can offer a sense

of a secure base (Adshead, 1998), especially when an individual's life outside the service may be experienced as threatening, unpredictable and chaotic. However, again, whilst there is growing theoretical interest in this area, there is little cohesive sense as to the degree in which clinical studies within the specific context of psychosis validate or further shape current arguments for the value of attachment theory within psychiatric settings.

Challenges in the Assessment of Adult Attachment

A final note of importance prior to reviewing the clinical literature on adult attachment and psychosis is an acknowledgement of the implications of variations in attachment assessment methodology. Historically, the assessment of adult attachment has remained an area of much debate, largely arising from the division of early work into two traditions, the romantic tradition which focuses on close romantic relationships in adulthood (Hazan & Shaver, 1987), and the parenting tradition, which was largely driven from a developmental school of thought (George, Kaplan & Main, 1985; Main, Goldwyn & Hesse, 2003). A further perspective on adult attachment was offered by Bartholomew (1990) and Bartholomew and Horowitz, (1991) in an attempt to highlight these differences. The significant differences between traditions means that research carried out within the paradigms should not be viewed as readily interchangeable (Roisman *et al.*, 2007). A recognition of the general differences between these traditions is becoming well documented in the attachment literature and will not be repeated here (*e.g.* Bartholomew & Shaver, 1998; Berry *et al.*, 2007a; Crowell & Treboux, 1996; Ma, 2006). However, a brief summary of each approach, associated attachment organisations, methodologies and key limitations is provided in Table 1.

A note on 'proxy' measures of attachment

Further confusion within the attachment literature may be caused by the inappropriate use of constructs and related tools as a direct substitute for assessing adult attachment. For example, studies using the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979) have made a valuable contribution to discussions on early adverse experiences (*i.e.* perceptions of parental care and overprotection) and

attachment in psychosis (e.g. Berry *et al.*, 2007a). Further investigation is required as to the components of early care which may directly relate to vulnerable attachment states of mind, or offer protection from them. The divergence between measures of attachment and PBI-related dimensions has been argued to be particularly noticeable where early experiences have been difficult and complex (e.g. Manassis *et al.*, 1999), or there are poorer education levels amongst participants (e.g. Favaretto, Torresani & Zimmermann, 2001). As such, the use of the PBI as a sole proxy for adult attachment within a clinical context needs to be more thoroughly justified in future research, and studies relying on insights gained from this tool alone will be outside of the scope of the current review.

Summary

Whilst attachment theory offers a potentially powerful framework within which to explore psychosis-related phenomena, there is little current clarity regarding the quality and consistency of findings relating to attachment and psychosis from studies carried out within clinical populations in this field. As such, a systematic review of this literature may offer valuable insights into the arising debates regarding relationships between attachment and psychosis-related phenomena, including the presentation of symptoms, interpersonal functioning and service engagement.

Table 1: Overview of traditions and methodologies within attachment research.

	Developmental / Parenting Tradition (Main <i>et al.</i>, 2003)	Romantic Tradition (Hazan & Shaver, 1987)	Bartholomew and Horowitz (1991)
Sub-cultural influences	Clinical, psychodynamic & developmental approaches.	Personality & social psychology	Personality & social psychology
Original focus (all adult attachment)	Current representations of past parental relationships & impact on own parenting.	Attachment in chronic loneliness / current romantic relationships.	Expansion of attachment models to distinguish avoidant types.
Assessment methodology	Narrative interview (<i>e.g. Adult Attachment Interview AAI; George et al., 1985</i>)	Self-report questionnaires (<i>e.g. Hazan & Shaver, 1987.</i>)	Self-report questionnaires & narrative approaches.
Associated adult attachment classifications	<div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: fit-content;"> <p style="text-align: center;"><i>Secure-Autonomous</i> <i>Preoccupied</i> <i>Dismissing (Avoid)</i> - <i>Unresolved</i></p> </div> <p>NB: Kobak (1989) Dimensional sorting by: Secure / Anxious Hyperactivating /Deactivating</p>	<p><i>'Three category model'</i></p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: fit-content;"> <p style="text-align: center;"><i>Secure</i> <i>Anxious -Ambivalent</i> - <i>Avoidant</i> -</p> </div> <p>NB: Brennan <i>et al.</i> (1998) dimensional approach: Anxiety / Avoidance</p>	<p><i>'Four category model'</i></p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: fit-content;"> <p style="text-align: center;"><i>Secure</i> <i>Preoccupied</i> <i>Dismissing (avoidant)</i> <i>Fearful (avoidant)</i> -</p> </div> <p>Two dimensions: Positive sense of self Positivity sense of other (Anxiety / Avoidance)</p>
Timeframe	Retrospective reporting of child-parent relationship	Contemporary account of adult relationships	Retrospective & contemporary accounts.
Outcome	(Possibly) unconscious, internal working models of parent-child attachment.	Consciously reported patterns of adult-adult relating.	Conscious & (possibly) unconscious, past & current representations.
Common interpretative methodology	Interpretation of the consistency, coherence and form of narrative.	Scoring of directly reported data.	Both narrative interpretation and self report scoring.
Key benefits	<ul style="list-style-type: none"> Not reliant upon individuals capacity to consciously report internal states. Less susceptible to confounders relating to memory, expectation effects or intelligence. 	<ul style="list-style-type: none"> Easy and quick to administer and score. Taps into contemporary examples of adult attachment behaviour. 	<ul style="list-style-type: none"> Offers flexibility of methodology or domain of attachment. Aids comparison across traditions.
Key limitations	<ul style="list-style-type: none"> Resource intensive. May not represent contemporary adult- adult attachments. 	<ul style="list-style-type: none"> Can lose precision if used categorically. Relies on accuracy of self-report and access to conscious internal states. 	<ul style="list-style-type: none"> Shares limitations of both methodologies of each tradition.

Systematic Review Rationale and Objectives

This review aims to make a valuable extension to the current literature by providing a current and comprehensive critical synthesis of the evidence base focused on issues directly relating to adult attachment within clinical populations with a psychosis-related disorder, making a clearer distinction between the attachment paradigms, associated methodologies and participant samples used in the studies. As well as providing a more generalised overview, the study seeks to address the following question:

How does adult attachment organisation in adults with psychosis relate to the presentation of psychosis-related symptoms, interpersonal functioning and service engagement within a clinical population ?

Method

Systematic Review Protocol

This systematic review referred to guidance from the PRISMA statement (Preferred Reporting Items for Systematic reviews and Meta-Analyses; Moher *et al.*, 2009) and the Centre of Reviews and Dissemination (CRD, 2008), to increase quality and transparency of process and minimise bias. To ensure a recent review had not already been completed in this field, an initial search was carried out via Database of Abstracts of Reviews of Effects (DARE) using the term ['psychosis' OR 'schizophrenia'] AND 'attachment' and via the Cochrane Database of Systematic Reviews using the term 'psychosis'. No replica reviews were identified from this search.

The review adds to the current literature by i) offering a more up to date synthesis of literature, taking into account significant contemporary developments in theory and empirical research in this area, ii) adding clarity of focus by looking specifically at studies relating to clinical populations with psychosis and iii) providing a systematic,

critical appraisal of the literature specifically adapted to recognise issues specific to the assessment and interpretation of adult attachment methodologies.

Search strategy

A literature search was conducted using the following databases: ASSIA (via ProQuest, 1980 to November 2012); Medline (via OvidSP, 1980 to November 2012); EMBASE (via OvidSP, 1980 to November 2012); CINAHL Plus (via EBSCO, 1980-November 2012); PsycINFO (via OvidSP, 1980 to November 2012) and The Cochrane Library (via Wiley, 1980-November 2012). The search was carried out using the string 'attachment' AND ['psychosis' OR 'schizophrenia'] within the domains of abstract or keywords. A further search was carried out using the University of Edinburgh EBSCO-hosted 'Searcher' discovery service. All searches were limited to the English language. An initial review of titles and abstracts was followed by more detailed screening of full text articles. To reduce publishing bias, key authors were contacted to enquire about unpublished results of relevance to the review. A manual review of the references of chosen articles and key author bibliographies was completed to identify any further relevant papers. Finally, an issue by issue 'manual search' of the *Journal of Schizophrenia Research* (August 2011 to August 2012) was carried out, along with an electronic search of the archive of this journal using the keyword 'attachment'.

Eligibility criteria

Studies were eligible for inclusion if they were focused on the role of attachment amongst a clinical population with a primary diagnosis of schizophrenia or specific psychosis-related disorder. Specifically eligibility criteria as outlined below, were concurrently applied:

- **Source:** Peer reviewed, full-text journal articles were included in the review. Journal-referenced conference materials were only considered if sufficient detail was provided.

- **Design and Methodology:** Primary, quantitative research studies were included in the review. Commentaries, reviews, case series or single case reviews were excluded from the selection.
- **Study focus:** Studies looking at the psychological issues specifically relating to adult attachment and psychosis were included in the review. Studies focusing on post-partum psychosis were excluded due to the specialised nature of this phenomenon.
- **Measures:** Only studies using tools specifically designed to assess adult attachment were included in the review.
- **Diagnosis:** Studies looking at a clinical population of adults with a stated primary diagnosis of a psychosis-related disorder (including schizophrenia or schizo-related disorders, bipolar disorder with symptoms of psychosis, affective disorders with associated symptoms of psychosis and unspecified psychosis disorders). Studies using a general psychiatric population were excluded, unless specific emphasis was placed on psychosis with at least 60% of the sample population having a psychosis-related disorder. Studies focusing on ‘organic’ psychosis or psychosis with an identified physical cause (e.g. dementia), were excluded from the review.
- **Age Range:** To include early onset studies, the age limit was defined as 16 years and over.

Search results

The results of the search strategy are summarised in Figure 1. An initial 1076 publications were identified from the database search (ASSIA [22]; MEDLINE [318], EMBASE [282], CINAHL[23], PsycINFO[303], Cochrane Library [37] and University ‘Searcher’ [98]). Screening resulted in 18 articles being included in the review.

Fig.1 : Flow of information through systematic review selection process

Identification

No. of records identified from
database search

1076

No. of additional records identified through
other sources

13

Screening

No. of records after initial screening of titles and
abstracts

164

No. of records after duplicates removed

73

No. of records for more detailed screening
of abstracts

86

No. of records excluded

26

No. of records for full text assessment of eligibility

60

No. of records excluded

11

Full text unavailable: 5
Insufficient detail to assess eligibility: 6

No. of full text articles assessed

49

No. of full text articles excluded: **31**

Study focus outside scope of review: 1
No valid measure of adult attachment: 18
Non-clinical population: 3
Insufficient / ill-defined representation of
psychosis in study population: 8
Duplicate study: 1

Included

No. of studies included in systematic review

18

Critical Appraisal

Given the relatively limited number of studies fulfilling the criteria for this review, studies were not screened for quality prior to inclusion. The majority of the studies meeting eligibility criteria were of an observational rather than experimental epidemiology. There is not yet a recognised ‘gold standard’ criteria or appraisal tool for the critical evaluation of non-RCT study designs (Sanderson, Tatt & Higgings, 2007), and criticisms have been made regarding the misuse of published reporting guidelines for evaluation purposes for observational studies (da Costa, Cevallos, Altman, Rutjes & Egger, 2011). The focus of this review also necessitated the consideration of attachment-specific elements to the quality appraisal process. Therefore, a tailored method of quality assessment was adopted, combining a systematic approach with a relevant, individual assessment of key aspects of each study in context of the aims of this review (Pettigrew & Roberts, 2006). A twenty-nine item grid¹ was developed based on the guidelines published by the Critical Appraisal Skills Programme UK (CASP; Public Health Resource Unit, 2006), with reference to aspects of quality criteria assessment outlined by the CRD (2008). This grid was refined following an initial pilot using three of the review articles.

The extraction grid was completed by the author for each of the eighteen included studies in the review. To increase the validity and reliability of this process, a randomly chosen sample of seven studies were second-rated by a consultant clinical psychologist, with a supervisory role on the project. A 92% agreement or partial agreement (*i.e.* criteria felt to be at least partially met) was achieved between-raters. On further discussion, 100% agreement was reached, with the most common area of discrepancy being the perceived sufficiency of described sample data. An overall score was then assigned to each of the quality categories, based on a summation of responses within the data extraction grid (see Table 4).

¹ The extended grid has been provided for as part of the thesis submission in Appendix A.

Results

Overview of Participant Samples

An overview of the participant profiles for the included studies is provided in Table 2. Sample size for the studies ranged from $n=24$ to $n=156$ (mean of 76). All the participant samples had a greater representation of male participants, with the exception of one study (Tyrell *et al.*, 1999).

Overview of Study Design and Measures.

Table 3 provides a descriptive summary of each study. The majority of studies adopted a convenience sampling approach, based on a geographical service cohort ($n=14$).

Study Quality

Table 4 provides a summary of the critical appraisal rating categories and scores given to each of the articles. None of the studies fully met all of the quality criteria, with only three of the studies being rated as 70% or above on the quality scale (Berry *et al.*, 2007; Berry *et al.*, 2012; Kvirgic *et al.*, 2012a). Whilst in general study focus and depth of discussion was strong, the generalisability of findings, transparency of recruitment process and features relating to the measurement of attachment were areas of relative weakness across a number of studies. This suggests scope for more transparent and rigorous study design, consideration of methodology and clarity of reporting to aid consolidation of findings in this area.

Table 2: Descriptive table of participant samples in reviewed studies

	Dozier and Lee (1995)	Tyrrell <i>et al.</i> (1999).	Tait <i>et al.</i> (2004)	Berry <i>et al.</i> (2007c)	Couture <i>et al.</i> (2007).	Ponizovsky <i>et al.</i> (2007)	Berry <i>et al.</i> (2008)	Berry <i>et al.</i> (2009)	Blackburn <i>et al.</i> (2010).
Sample Size (n)	76	54	50	58	96	30	96	80	78
Inpatient / Community mental health outpatient	Unclear. 'Mental health centre patients '	'Community based setting'	Community outpatient	Community outpatient	Unspecified. 'First episode psychosis (FEP)'	Long term hospitalised inpatients.	Inpatient & community outpatient	Inpatient & community outpatient	Inpatient.
Diagnosis:									
<i>Schizophrenia</i>	47(61.9)	31(57.4)	Breakdown unspecified.	47 (81)	-	30 (100)	77 (80.2)	66 (82.5%)	69 (88.5)
<i>Schizoaffective disorder</i>		9(16.7)	unspecified.	11 (19)	-		15 (15.6)	13 (16.3%)	
<i>Psychotic episode (NOS)</i>			'schizophrenia or related disorders'.		-		4 (4.2)	1(1.3%)	
<i>Bipolar Disorder</i>	27(35.5)	8 (14.8)			-				5(6.4)
<i>Other</i>	2 (2.6)	6 (11.1)			-				4(5.1)
Mean Age in years (SD)	-	41 (range 25-62)	33.8(12)	45.91(13.5)	23.7(4.7)	38.4(10.2)	44 (12.8)	44(13.3)	39(13.78)
Gender:									
<i>No .Male (%)</i>	45(59.2)	22(40.7)	31(62)	37 (63.8)	63(65.6)	30(100)	66 (68.8)	55 (66.3%)	62 (79.5)
<i>No. Female (%)</i>	31(40.8)	32(59.3)	19(38)	21 (36.2)	33(34.4)	-	30 (31.2)	25 (31.2%)	16 (20.5)
No. of inpatient admissions									
<i>Median(range)</i>	-	-	-	-	-	-	5 (0-20)	5(0-20)	4.64(1-22).
<i>Mean (SD)</i>	-	-	-	6(3.8)	-	-	-	-	-
Notes:	Sample part of a longitudinal treatment effectiveness study.	Substance abuse disorder comorbidity (48%).	Psychosis not secondary to substance misuse or mood disorder. Mean duration of illness in yrs (SD) 7.2(9.71).	At least monthly contacts with keyworker. Clinical participants recruited from larger sample (Berry <i>et al.</i> , 2008).	Age 15-35. FEP within last 2 years. Participants - subset of a treatment adherence study for FEP. Historical comparison used (Paquette <i>et al.</i> , 2001)	-	'Acute' subgroup (n= 21). Inpatients. Assessed during acute phase and post remission. 'Stable' subgroup (n= 33). Community. No relapse at 6 month follow up.	Mean duration of illness in yrs (SD)= 19(12.8)	Mean duration of illness in yrs (SD)= 12(9.66) Detained patients (n=40).

'-' = unspecified / data not available; n/a= not applicable; SD= standard deviation; NOS = Not Otherwise Specified.

Table 2 (cont.): Descriptive table of participant samples in reviewed studies.

	Mulligan and Lavender, (2010)	Picken <i>et al.</i> (2010)	Macbeth <i>et al.</i> (2011)	Ponizovsky <i>et al.</i> (2011)	Arbuckle <i>et al.</i> (2012)	Berry <i>et al.</i> (2012)	Kvrgic <i>et al.</i> (2012a)	Kvrgic <i>et al.</i> (2012b)	Owens <i>et al.</i> (2012)
Sample Size (n)	73	110	34	100	24	73	127	156	49
Inpatient /Community mental health outpatient	Community outpatients	Unspecified	Unspecified (early intervention service-users)	Community outpatient.	Inpatient (Low / Medium secure rehabilitation)	Inpatient & community outpatient	Community outpatients	Community outpatients	Unclear '24 hour rehabilitation service' patients
Diagnosis: <i>Schizophrenia</i> <i>Schizoaffective disorder</i> <i>Psychotic episode (NOS)</i> <i>Bipolar Disorder</i> <i>Other</i>	Breakdown unspecified.	87(79) 13(12) 9(8) 1(1)	11 (32.4) 4 (11.8) 11 (32.4) 8 (23.4)	100(100)	Breakdown unspecified. 'Schizophrenia or related psychosis'	58(79.5) 7(9.6) 8 (11)	90(70.9) 37(29.1)	102(65.4) 54(34.6)	41 (83.7) 3 (6.1) 5 (10.2)
Mean Age in years (SD)	39 (10.49) m 48.6 (13.5) f	38 (range18-61)	-	40.3 (11.2)	32.4 (8.7)	39.1(11.3)	44.6(11.53)	44.5(11.67)	38.06(11.55)
Gender: <i>No .Male (%)</i> <i>No. Female (%)</i>	55(75.3) 18(24.7)	99(90) 11(10)	20(58) 14(42)	70 (70) 30 (30)	15 (62.5) 9 (37.5)	59 (82.8) 14 (17.2)	84(66) 43(34)	102 (65.4) 54 (34.6)	42 (85.7) 7 (14.3)
No. of inpatient admissions <i>Median(range)</i> <i>Mean (SD)</i>	- -	- 3(0-10)	- -	- 4.1(3.9)	- -	4(0-20) -	- 8.52(11.34)	- 8.21 (6.45)	2 (0-15) -
Notes:	Psychosis not secondary to substance misuse. No sig. differences in gender demographics. Historical comparison (Andersson & Perris, 2000).	All participants part of larger MIDAS RCT. Comorbid subs. misuse: alcohol (61%) ; drug (39%). Median years since onset (range) = 13(1-46)	Psychosis not secondary to substance misuse. Historical comparisons: <u>normative</u> (van IJzendoorn & Bakermans-Kranenburg, 1996.), <u>chronic clinical</u> (Tyrrell <i>et al.</i> , 1997).	Stabilised on medication. Mean duration illness, years (SD) = 15(10) 81% 'paranoid type'. Employed (64%).	-	Inclusion: Score of 3+ PANSS. Participants part of either Berry <i>et al.</i> (2008) study or MIDAS trial (substance misuse in schizophrenia). Mean duration illness, yrs (SD) = 13.7(10.7)	Psychosis not secondary to substance misuse. Mean duration illness, yrs (SD) = 18.63(11.82) 77.5% sheltered employment or unemployed.	Psychosis not secondary to substance misuse. 'Maintenance phase' of txt (no acute sympt). Mean duration illness, yrs (SD) = 18.63(11.82) 88.5% in sheltered emp. or unemployed.	Age 16-65 yrs. 92% of sample unemployed.

‘-’ = unspecified / data not available; n/a= not applicable; SD= standard deviation; NOS = Not Otherwise Specified; DUP= Duration Untreated Psychosis.

Table 3: Summary of included studies

	Dozier and Lee, 1995 (USA)	Tyrrell <i>et al.</i> 1999 (USA)	Tait <i>et al.</i> (2004) (UK)	Berry <i>et al.</i> (2007c) (UK)	Couture <i>et al.</i> (2007). (Canada)
Design	Cross-sectional	Cross-sectional	Prospective cohort	Cross-sectional	Cross-sectional
Attachment dimension in focus	Attachment and self-reported / clinician rated psychiatric symptomatology.	Clinician and client attachment states of mind.	Attachment and personal resilience to adapting to psychosis.	Attachment style in general, parental and psychiatric staff relationships.	Attachment style & personality characteristics on social dysfunction in FEP.
Attachment tradition & assessment methodology.	Narrative AAI. Q-sort analysis (dimensional insecure representations i.e. ‘hyperactivating’ [preoccupied-type], or ‘deactivating’ [avoidant/dismissing-type]).	Narrative AAI Q sort analysis (deactivating / hyperactivating)	Self report RAAS Subscales include ‘comfort with being <i>close</i> to others’, ‘inability to <i>depend</i> on others’ and ‘ <i>anxiety</i> about interpersonal rejection’.	Self report PAM Self and informant report versions	Self report ASQ Factor analysis (Paquette <i>et al.</i> , 2001). Dimensional subscales ‘ <i>avoidance of social relations</i> ’ & ‘ <i>preoccupation with being loved</i> ’. Categorical i.e. autonomous /secure; avoidant; preoccupied and ambivalent.
Key findings	Predominance of deactivating type (65% sample). Client and professional ranking of symptoms significantly deviated. Hyperactivating individuals reported <i>more</i> symptoms. No difference in symptom <i>type</i> . Deactivating individuals: lower self-reported distress. But rated by clinician’s as <i>more</i> distressed and symptomatic.	More deactivating clients had better outcomes and worked better with less deactivating case managers.	Insecure attachment associated with greater disengagement from professionals. ‘Sealing over’ group – greater belief of being perceived negatively by others. No difference in view of self. ‘Sealing-over’ recovery style scored lower on <i>close</i> and <i>depend</i> and higher on <i>anxiety</i> factors than ‘integration’ group. Fear of rejection correlated with positive symptoms of psychosis.	Diminished social networks found in clinical group. Attachment style correlated across close general relationships, key worker and parental relationships. Lower degree of attachment anxiety in key worker vs. general / parental relationships. Less avoidance in parental relationships vs. general relationships.	Prevalence of insecure attachment in clinical group (both genders). Gender distribution within category varied significantly. FEP (vs. non-clinical): Higher proportion of <i>preoccupied</i> (females 39%, males 63%), <i>ambivalent</i> (f 32%, m 28%). Lower proportion of <i>secure /autonomous</i> (f. 21%, m.5%). FEP <i>avoidant</i> (f. 7%, m. 4%) vs. non-clinical (f. 3%, m.36%) Symptom measures unrelated to social functioning.

Table 3 (cont.)

	Ponizovsky <i>et al.</i> (2007) (Israel)	Berry <i>et al.</i> (2008) (UK)	Berry <i>et al.</i> (2009) (UK)	Blackburn <i>et al.</i> (2010). (UK)	Mulligan and Lavender(2010). (UK)
Design	Cross-sectional ‘case control’	Part 1: Cross- sectional Part 2: Prospective cohort	Cross-sectional	Cross-sectional	Cross-sectional
Attachment dimension in focus	Attachment style distribution and association with symptom patterns and course of illness	Part 1: Attachment style, symptoms of psychosis, interpersonal difficulties and therapeutic relationships Part 2: Changes in attachment and illness severity.	Insecure styles of attachment, early caregiver experiences and childhood trauma	Service users’ attachments to inpatient services	Gender, attachment, representation of parental experiences and recovery style in psychosis
Attachment tradition & assessment methodology.	Self report Hazan and Shaver (1987). (Secure, avoidant & anxious/ambivalent).	Self Report PAM Self report and informant report versions.	Self Report PAM Self report version.	Self Report PAM Self report version.	Self report ASQ Five factor structure: Secure (<i>confidence</i>). Insecure (<i>discomfort with closeness; need for approval; preoccupation with relationships & rel’ps as secondary to achievement</i>)
Key findings	Significantly lower secure attachment, and higher avoidant attachment in clinical group vs. non-clinical comparison. Greater severity of positive symptoms associated with insecure attachment. Negative symptoms only with avoidant attachment. Insecure attachment associated with earlier age of onset. Avoidant attachment associated with longer hospitalisation.	Avoidant attachment correlated to paranoia & positive/ negative symptoms. ‘Attention seeking’ grp -higher attachment anxiety. ‘Hostile’ group - higher avoidance. Negative correlation between attachment avoidance (not attachment anxiety) and therapeutic alliance. Attachment style relatively stable over time (some shift in ‘anxiety’ & severity of hallucinations.	Positive association between avoidant attachment and symptom severity. Moderate correlation between depression and attachment anxiety. 92.5% of participants experienced at least one trauma. Higher attachment anxiety in patients who experienced ‘ <i>trauma with significant others</i> ’ in childhood. Attachment avoidance negatively associated with <i>level of care in childhood</i> .	Adult attachment, depression and section status - significant independent associates of attachment to services. More insecure attachment associated with lower service attachment. Depression was positively correlated with hallucinations but not delusions.	Higher levels of insecurity (except ‘need for approval’) reported for clinical participants vs. non-clinical comparison. Men – higher scores on ‘discomfort with closeness scale’. Women – higher scores on ‘preoccupation with relationships scale. Limited correlations found between insecure attachment and recovery style.

Table 3 (cont.)

	Picken <i>et al.</i> (2010) (UK)	Macbeth <i>et al.</i> (2011). (UK)	Ponizovsky <i>et al.</i> (2011) (Israel)	Arbuckle <i>et al.</i> (2012). (UK)
Design	Cross-sectional	Cross-sectional	Cross-sectional	Cross-sectional.
Attachment dimension in focus	Trauma history, attachment and therapeutic working alliance.	Attachment, reflective functioning (RF), engagement and adaptation to FEP.	Attachment style, affective coping style and psychotic symptoms.	Attachment style across personal and professional service relationships.
Attachment tradition & assessment methodology.	Self Report PAM <i>Self report version.</i>	Narrative AAI <i>Forced, three-way classification (i.e. secure /freely autonomous, dismissing and preoccupied).</i>	Self report RQ <i>Four categories – fearful/ avoidant; secure; preoccupied and dismissing /avoidant.</i>	Self Report PAM <i>Self and informant report versions.</i>
Key findings	Significant trauma experienced by participants (91% prevalence). Underestimated by care coordinators. Anxious attachment correlated to number of interpersonal traumatic events and severity of posttraumatic symptoms. Higher avoidant attachment associated with fewer reported traumatic events. No significant correlation between working alliance and trauma.	Insecure attachment higher in FEP group vs. non- clinical young adult grp. Secure attachment higher in FEP vs. chronic psychosis grp. Secure and preoccupied groups higher RF than dismissing attachment group. Dismissing grp: poorer service engagement. Preoccupied grp: poorer treatment adherence. No gender differences. No correlation for RF with symptoms, or attachment and symptoms.	Participants predominantly securely attached (53%). <u>Preoccupied</u> : more severe positive symptoms, higher reported affective symptoms and elevated emotional distress. <u>Fearful-avoidant</u> : greater severity of hallucinatory behaviour. <u>Dismissing-avoidant</u> : anxiety only. Preoccupied/ fearful-avoidant styles (plus anxiety/depression or emotional distress), predicted levels of psychotic symptoms.	Avoidant / Anxious pattern correlated between general and professional relationships. Strength of anxiety/ avoidance varied between relationships (general relationships > keyworker / team relationships). Attachment anxiety higher in team vs. keyworker relationships. More avoidant (staff-reported) viewed as more hallucinatory (by staff). More delusional (self-reported), more avoidant of staff (self-reported). Only partial relationship between self and informant ratings of attachment.

Table 3 (cont.)

	Berry <i>et al.</i> (2012) (UK)	Kvrgic <i>et al.</i> (2012a). (Switzerland)	Kvrgic <i>et al.</i> (2012b) (Switzerland)	Owens <i>et al.</i> (2012). (UK)
Design	Cross-sectional.	Cross- sectional	Cross-sectional	Cross-sectional
Attachment dimension in focus	Attachment & severity/ nature of, and distress caused by, voices.	Validation of German version of the PAM.	Attachment style and quality of therapeutic alliance.	Attachment, emotion regulation and staff-patient relationships.
Attachment tradition & assessment methodology.	Self Report PAM <i>Self report version.</i>	Self Report PAM <i>Self report version.</i>	Self Report PAM <i>Self report version.</i>	Self Report PAM <i>Self report version.</i>
Key findings	Participants who perceived voices as critical and rejecting or threatening self-reported higher levels of attachment avoidance. Significant, small positive associations between attachment anxiety, severity of voices and distress caused by voices. Not for attachment avoidance.	Greater prevalence of higher avoidant style attachment i.e. 65%. (27% higher anxious attachment, 8% ‘balanced’) Avoidant attachment correlated to positive symptoms but not negative symptoms. Attachment avoidance predicted poor therapeutic relationship (patient-reported).	Stronger recovery orientation, lower self-stigma and more insight independently associated with therapeutic alliance (especially in maintenance phase of txt), more than with symptoms, avoidant attachment style, age or depression.	Insecure attachment correlated with global emotion regulation difficulties (esp. attachment anxiety). Difficulty type varied by style (e.g. <i>avoidance</i> : non-acceptance of emotional responses, poor emotional awareness; <i>anxiety</i> : difficulties with goal-directed behaviour when upset, impulse control & lack of emotional clarity). Attachment anxiety (but not avoidance) predicted emotion regulation over and above symptoms and negative affect. Negative correlation between the patient-reported therapeutic alliance and global emotion regulation difficulties. Staff rated therapeutic alliance more highly than patients did.

AAI= Adult Attachment Interview (George *et al.*, 1985); RAAS = Revised Adult Attachment Scale (Collins, 1996); PAM = Psychosis Attachment Measure (Berry *et al.*, 2006); ASQ= Attachment Style Questionnaire (Feeney *et al.*, 1994); RQ= Relationship Questionnaire; Bartholomew & Horowitz, (1991); FEP = First Episode Psychosis.

Table 4: Summarised Quality Rating Categories and Scores

	0	1	2	3
Study Focus	Insufficient information provided to ascertain the aims and scientific justification for the study.	Author provides some relevant information regarding study focus but lacking in some clarity and/or detail.	Author clearly states aims of study. Sufficient background / justification given but there may be minor gaps, or limited clarity of hypotheses.	Author provides a clear outline of study aims, relevant hypotheses and a comprehensive and relevant scientific justification for study.
Recruitment	Insufficient information provided regarding recruitment process, setting, eligibility, sampling and recruitment rates. Significant gaps in the information which would prevent replication and/ or impact on the generalisability of findings.	Some information regarding recruitment process, eligibility criteria, setting and response rates may be provided but some notable gaps. Sampling may be convenience.	Sufficient information provided for recruitment process and eligibility criteria for replication / setting. May be minor gaps. Sampling may be convenience or representative.	Comprehensive and relevant information regarding recruitment process, eligibility criteria, setting and response rates and drop out analysis provided. Sampling is representative.
Sample Characteristics	Insufficient information provided regarding sample profile, which significantly limits the generalisability of findings.	Some demographic and clinical sample details provided, however, there may remain some notable gaps or lack of clarity or queries about sample homogeneity.	Study provides a sufficient level of sample demographic and clinical characteristics, although there may be some minor gaps.	All specified sample demographic and clinical characteristics are clearly and fully described. Sample homogeneity can be readily ascertained.
Measurement of Attachment	Non standardised measure of attachment used.	Standardised measure of attachment used. Some notable gaps/ lack of clarity across some or all of the following; stated psychometric properties, use within clinical setting, completion protocol, relationship domain assessed or issues of applicability of use and interpretation of results across relationship domains.	Standardised measure of attachment used with confirmation of psychometric properties and relevance to clinical setting. May be some minor gaps in completion protocol or limited consideration of issues of applicability of tool across relationship domains.	Standardised measure of attachment used with psychometric properties clearly stated and applicability of use confirmed within a relevant setting for the study. Relationship domain and completion protocol clearly stated and consideration of issues of tool relevance and transferability of findings across relationship domains.

Table 4 (cont.)

	0	1	2	3
Measurement of Other Variables	Non standardised measures used without established psychometric properties. No consideration of error effects of multiple measures.	Measures may be a mix of standardised and non standardised. May be limited or no discussion of either psychometric properties or validity for use with clinical / psychosis population. Completion procedures may not be adequately described.	Measures mostly standardised with psychometric properties acknowledged. Where applicable – confirmation of relevance of tools for use with clinical population for majority of tools. Completion procedures clear. May be some minor gaps.	Measures all standardised with clear, established psychometric properties. Measures were all clinically relevant for use with psychosis and completion procedures made clear.
Results	Results poorly reported with inadequate or inappropriate analysis, preventing clear conclusions being drawn.	Results and analysis adequate to allow some conclusions to be drawn, but some major gaps in reported statistics etc. remain.	Results and analysis appear appropriate and relevant with most descriptive statistics clearly outlined. Consideration of dropout rates may be made. May be some minor gaps or slight lapses in clarity.	Results and analysis are comprehensive and relevant including clearly reported descriptive statistics. Participant dropout rates reported and considered.
Discussion	Conclusions drawn from the study have a poor fit with the data. No recognition of limitations of methodology. Inadequate comparison of results to existing evidence base and poor consideration of clinical issues.	Conclusions drawn from the study fit with the data but may be overly brief with inadequate reference back to the existing evidence base. Consideration of methodological and/ or clinical implications of study may be limited.	Conclusions drawn from the study fit well with the data. Good discussion of the results in context of existing evidence base. Adequate consideration of methodological limitations or clinical implications. Some minor gaps may remain.	Conclusions drawn from study have good fit with data and are well embedded in existing evidence base. Made clear how current results extend evidence base and the clinical implications of this. Comprehensive consideration of methodological limitations of study.
Generalisability	Study has poor external validity. Significant limitations or clarity on sample size, participant population and methodology, which limits application beyond the scope of the study.	Study has reasonable external validity. However, some notable limitations to sample size, participant population or methodology, or clarity of these within the study, may impair external validity.	Study appears to have good external validity, although some limitations to sample size, participant population profile and methodology may need to be considered.	Study appears to have strong external validity and could be readily applied to other clinical sites with significant confidence.

Table 4 (cont.)

Study (listed chronologically)	Study Focus	Recruitment Process	Sample Characteristics	Measurement of Attachment	Other Variables	Results	Discussion	Generalisability	Total Score (max 24)	Sample Size (n=)
Dozier and Lee, 1995	1	0	1	1	1	2	2	1	9	76
Tyrrell <i>et al.</i>, 1999	3	0	2	2	1	2	2	1	13	54
Tait <i>et al.</i>, 2004	3	2	1	1	1	2	3	1	14	50
Berry <i>et al.</i>, 2007	2	2	2	3	(2)*	2	2	2	17	58
Couture <i>et al.</i>, 2007	2	1	1	2	2	1	2	1	12	96
Ponizovsky <i>et al.</i>, 2007	3	1	2	1	2	2	3	1	15	30
Berry <i>et al.</i>, 2008	3	1	2	1	1	2	2	2	14	96
Berry <i>et al.</i>, 2009	2	2	2	1	2	2	2	2	15	80
Blackburn <i>et al.</i>, 2010	2	1	2	1	2	2	2	2	14	78
Mulligan and Lavender, 2010	3	2	1	1	2	2	2	1	14	73
Picken <i>et al.</i>, 2010	1	1	1	1	2	2	2	1	11	110
Macbeth <i>et al.</i>, 2011	3	1	2	2	2	2	3	1	16	34
Ponizovsky <i>et al.</i>, 2011	3	2	2	1	2	2	3	1	16	100
Arbuckle <i>et al.</i>, 2012	2	1	1	3	2	2	2	1	14	24
Berry <i>et al.</i>, 2012	3	2	2	2	2	2	2	2	17	73
Kvrgic <i>et al.</i>, 2012a	3	2	3	2	3	2	3	1	19	127
Kvrgic <i>et al.</i>, 2012b	2	2	2	1	2	1	2	1	13	156
Owens <i>et al.</i>, 2012	3	2	1	1	2	2	3	2	16	49

*Berry *et al.* (2007) criteria not applicable therefore score substituted with mean score across other components to allow a final quality score to be calculated.

Assimilation of Findings

Adult attachment organisation, psychosis and symptomatology.

General associations between attachment and psychosis

Seven of the included papers in this review looked at general patterns of attachment amongst a clinical sample of adults with psychosis-related disorders. Four studies (Dozier & Lee, 1995; Kvirgic *et al.*, 2012a; Mulligan & Lavender, 2010 & Ponizovsky *et al.*, 2007) showed consistent findings in relation to a high prevalence of attachment insecurity within their clinical samples. Three of these identified a trend towards avoidant / dismissing or deactivating type attachment styles. The exception was Mulligan and Lavender (2010) who found that only men were likely to report higher levels of 'discomfort with closeness', whereas females scored higher in 'preoccupation with relationships' dimensions. However, it is worth noting that females in this sample were significantly older than males, and gender splits and characteristics between studies hinder accurate comparison.

Two first episode in psychosis (FEP) studies also identified a greater prevalence of insecure attachment-related dimensions in their clinical samples in comparison to historical, non-clinical comparison groups. Couture *et al.* (2007) found a larger proportion of males being classified within the preoccupied category of attachment than females, with both genders being least likely to fall into the (dismissing) avoidant classification. Conversely, a good quality study by Macbeth *et al.* (2011) failed to identify any gender differences but did find a high prevalence of avoidant (dismissing and fearful) type attachment. They also noted that their FEP group was more securely attached than a chronic psychosis population from a comparison study (Tyrrell & Dozier, 1997). Interestingly, they did find an age variation in their sample, with those who were insecure/dismissing being significantly younger than those with other attachment styles. This compares to the findings of Ponizovsky *et al.* (2007) who also identified a relationship between avoidant attachment and earlier age of onset.

Compared to these studies, only Ponizovsky *et al.* (2011) found a weighting towards securely attached individuals in their clinical sample, although an avoidant style was still the most prevalent insecure attachment category. However, whilst this study was of a relatively high quality compared to others, it is worth noting that the participants chosen may have been higher functioning, with higher employment rates, more likely to be in a relationship and with fewer past inpatient admissions than other studies.

Attachment and positive / negative symptoms of psychosis

Interestingly, whilst requiring more robust exploration, Dozier and Lee (1995) found significant differences between patient and clinician rated symptoms. Whilst those using hyperactivating attachment strategies self-reported higher levels of psychiatric symptoms than those using deactivating strategies, researchers and clinicians rated the latter as more symptomatic and distressed. With regard to categories of psychotic symptoms, Berry *et al.* (2008) only found associations between the dimension of attachment avoidance and severity of positive and negative symptoms and paranoia. Ponizovsky *et al.* (2007) also found that individuals reporting more severe positive symptoms were significantly more likely to have an insecure attachment style (avoidant or anxious / ambivalent), although negative symptom severity appeared to only be significantly associated with avoidant attachment. However, a similar quality study by Tait, Birchwood and Trower, (2004) found only a medium sized correlation between attachment anxiety and positive symptoms, with no other significant relationships. MacBeth *et al.* (2011) in their FEP study also found no significant associations between attachment classifications, symptoms and general psychopathology scores.

Attachment and specific symptoms of psychosis

Some of the attachment studies looked in more detail at the specific nature of symptoms in psychosis. Berry *et al.* (2012) for example, found a positive correlation between attachment anxiety and severity of, and distress caused by, voices. They also found a relationship between higher attachment avoidance and the experience of voices being critical and rejecting, or threatening. Ponizovsky *et al.* (2011) discovered preoccupied attachment was associated with higher ratings of delusions

and suspiciousness/ persecution, whereas the fearful-avoidant style was associated with higher levels of hallucinations. Dozier and Lee (1995) found that those individuals who were less secure were rated as more delusional, more likely to hear voices and more suspicious, particularly for those who were dismissing/deactivating in their attachment style. Arbuckle, Berry, Taylor and Kennedy (2012) identified that those with more prevalent auditory hallucinations were perceived by keyworkers to have greater attachment avoidance, and that individuals who experienced greater delusional symptoms, self-reported higher avoidance with the mental health team. Finally, Berry *et al.* (2008) looked at whether there were any correlations between changes in attachment scores and changes in symptoms scores between individuals in acute phases and remission. They found only a small to moderate correlation between changes in hallucinations and attachment anxiety.

Attachment and affective symptoms in psychosis

Finally, in relation to affective symptoms, Ponizovsky *et al.* (2011) found that both preoccupied and fearful-avoidant attachment styles were associated with higher levels of affective symptoms measured on the PANSS (i.e. anxiety, depression, guilt feelings and tension). The preoccupied attachment pattern was associated with high scores of self-reported emotional distress. A number of studies also included specific measures of depression. Arbuckle *et al.* (2012) found a significant correlation between depression and self-reported avoidance, whereas Berry *et al.* (2009) only found a correlation between depression and attachment anxiety. Kvrpic *et al.* (2012a) found a significant correlation between both insecure attachment dimensions and depression. Blackburn, Berry and Cohen (2010) found that depression amongst inpatients with psychosis was positively correlated only with hallucinations, not delusions.

Attachment and pathways to psychosis

A small number of studies in the review focused on empirically exploring hypotheses relating to pathways to psychosis, and the possible mediating factors linking attachment to this disorder.

Early experiences, trauma and attachment

Whilst the direct focus of this review is on adult patterns of attachment, it is interesting to note that there remain relatively few studies looking at early experiences and later patterns of adult attachment identified from this review, despite the strength of debates in this area. Both of the studies which included findings on trauma (Berry *et al.*, 2009; Picken, Berry, Tarrier and Barrowclough, 2010), found a high prevalence of interpersonal trauma-related history amongst inpatient and outpatient populations with psychosis, with significant associations between anxious attachment style and trauma. Whilst there is scope for a more robust replication of this study, Picken *et al.* (2010) identified that those with higher avoidant attachment patterns reported fewer traumatic events, and that care coordinator's knowledge of the nature and extent of trauma in a patient's history was poor.

Reflective functioning and emotion regulation

Given the growing theoretical interest in the possible mediating role of reflective functioning (RF) and mentalisation between attachment and psychosis, only one study directly looked at this topic (MacBeth *et al.*, 2011). This identified that RF in an FEP population, generally fell within the 'questionable or low' range, particularly for individuals with insecure/dismissing attachment. They also found no direct correlation between RF and symptoms of psychosis or service engagement.

An interesting study by Owens, Haddock and Berry (2012) considered the role of adult attachment and emotion regulation within psychosis, and found significant positive correlations between global emotion regulation difficulties and insecure attachment of both avoidant and anxious types. However, the specific difficulties associated with each attachment category varied. Attachment avoidance difficulties related to a failure to accept, engage with and understand emotional responses, whereas attachment anxiety difficulties were associated with control of emotion and appropriate emotional response. They also identified that poor emotion regulation was moderately, negatively correlated with therapeutic alliance, particularly within the context of attachment anxiety.

Attachment and interpersonal functioning in psychosis

Only two studies in the review directly considered issues of broader interpersonal problems and social functioning in adults with psychosis within an attachment context. Berry *et al.* (2007c) found their clinical group had an attachment network with a median of two close relationships, which was lower than that found in non-clinical samples (i.e. non-clinical average of four significant relationships; Ross & Spinner, 2001). Berry *et al.* (2008) also found insecure attachment to be associated with an increased severity of interpersonal problems. From an informant perspective, those viewed as more ‘attention seeking’ were more likely to be anxiously attached, whereas those seen as more ‘hostile’ were associated with avoidant attachment style.

Studies of recovery style in the review also raise issues relevant to possible social functioning within adults who have experienced psychosis. For example, Tait *et al.* (2004) found that individuals with a predominant ‘sealing-over’ recovery style (*i.e.* tends to avoid processing psychotic experiences), demonstrated significantly lower comfort with closeness, intimacy and ability to depend on others, and significantly higher fear of interpersonal rejection than those with an ‘integration’ recovery style (*i.e.* attempt to assimilate experience into a coherent perspective). Thus, such individuals are likely to be more prone to social withdrawal. A study of similar quality by Mulligan and Lavender (2010) showed more limited findings in relation to recovery style, identifying a medium sized correlation between poor integration achievement and a de-prioritisation of ‘relationships versus personal achievement’ amongst men in their sample.

Attachment relationships and mental health service engagement

Ten of the included studies directly addressed issues relating to patterns of attachment, psychosis and engagement with mental health professionals.

Do attachment patterns extend to professional relationships ?

Berry *et al.* (2007c) found that self-reported, insecure attachment styles did correlate across different relationship domains, including service relationships, general

relationships, keyworker relationships and parental relationships. However, lower levels of attachment anxiety were reported in keyworker versus general relationships, and greater attachment avoidance reported in general versus parental relationships. Consistent with this study, Arbuckle *et al.* (2012) also found correlations between insecure styles of attachment across different relationships (general, keyworker and team), as well as variations in the degree of insecurity expressed between domains. For example, insecure attachment was particularly high for general relationships compared to keyworker relationships.

Are attachment patterns associated with overall service engagement ?

Tait *et al.* (2004)'s study found that individuals with insecure-related attachment reported lower levels of service engagement, and were therefore more likely to disengage from professionals, although they found no distinction between categories of insecure attachment. Blackburn *et al.* (2010) also identified a significant negative relationship between security of attachment and service engagement, unaffected by symptom severity. They further identified that depression and section status were independently associated with service attachment. Macbeth *et al.* (2011) confirmed that a relationship between secure attachment and increased service engagement held for their FEP sample, but the difference was only significant when compared to insecure/dismissing classifications. However, a well rated study by Kvrjic *et al.* (2012a) found little correlation between poor service-level engagement and insecure attachment, although it is worth noting that their sample was older with a longer history of illness than the other studies, which may have influenced attitudes towards services over and above attachment patterns.

Attachment in individual therapeutic service relationships

With regards to the association between attachment style and therapeutic alliance, again findings were mixed. Berry *et al.* (2008) found a significant, negative correlation between self-reported attachment-avoidance and therapeutic alliance (as rated by both staff and patient), irrespective of symptom severity, but no similar effects for attachment anxiety. Kvrjic *et al.* (2012a) also found small correlations between patient-rated therapeutic relationship and attachment avoidance. A further

study led by the same author (Kvrgic *et al.*, 2012b) found that a better prediction of therapeutic alliance could be made when adding recovery orientation, self esteem related to self stigma and insight as variables alongside avoidant attachment . They also identified that positive symptoms appeared to make a negative contribution to therapeutic alliance, as mediated by self-stigma. Interestingly, Tyrrell, Dozier, Teague and Falloot (1999) took into account clinician as well as patient attachment states of mind when looking at therapeutic alliance. They identified that case managers who had a *less* deactivating style of attachment (*e.g.* more preoccupied) formed stronger alliances with *more* deactivating patients (*e.g.* more avoidant). Owens *et al.* (2012), also raised the need to consider a wider range of factors in studies of therapeutic alliance, identifying that global emotion regulation difficulties could impact negatively on therapeutic alliance. The findings also demonstrate possible variance between staff and patient ratings of therapeutic alliance.

Discussion

This review aimed to assess the quality of insights provided by the current clinical evidence base regarding the relationship between adult attachment organisation, the presentation of psychosis-related symptoms, interpersonal functioning and engagement within mental health services.

Limitations of the current literature

The review highlighted a number of important limitations to the existing literature. Firstly, the majority of studies in this review were observational in nature, and as such could have been more prone to bias, reduced validity and reliability and exaggerated estimates of effect (Pettigrew & Roberts, 2006; Khan, Kunz, Kleijnen & Antes, 2003). The relatively small sample sizes added to these risks, potentially reducing the external validity of conclusions. With the exception of one (Ponizovsky *et al.*, 2007), studies either failed to make comparisons between non-clinical populations or other diagnostic groups, or relied on historical comparison groups from other studies. Therefore, findings could have been skewed according to variables such as gender, co-morbidity, recruitment approach and severity of

disorder, given the convenience nature of many of the studies. The dominance of cross-sectional designs within studies also prevented conclusions being drawn regarding the direction of causality of effects.

Differences in attachment assessment approaches between studies were also problematic, offering little common denominator for comparison and potentially limiting the sensitivity of analysis by using broad categories of attachment. Indeed, a general psychiatric study by Dozier and Tyrrell (1997) demonstrated that participants (including some with schizophrenia), who were classified as avoidant within a three category model of attachment, would have fallen into a ‘disorganised’ group within a four-category model. This may be an important distinction to explore given a growing interest in the significance of disorganised attachment to the onset of psychosis (Liotti & Gumley, 2008). Equally, few studies appropriately considered the domain in which attachment was being assessed. For example, the use of romantic based measures of attachment in a population with few such relationships, could have resulted in results reflecting an ‘idealised’ view of relationships. Whilst the PAM (Berry *et al.*, 2006) was designed to address this limitation, the findings of the review suggest that it may still be valuable to specify the relationship an individual should hold in mind when completing these measures, given the potential different magnitudes of attachment difficulties associated with different relationships (Arbuckle *et al.*, 2012; Berry *et al.*, 2007).

The clinical context of studies also adds an additional layer of complexity and opportunities for bias amongst included studies. There is a risk that the heterogeneity of samples can be masked by a shared diagnostic label or service setting without a sufficient understanding of how this may affect attachment profiles. For example, the studies of Ponizovsky *et al.* (2011) and Kvrđić *et al.* (2012b) both focused on ‘community outpatients with schizophrenia’, yet employment rates and relationship profiles between the two were significantly different. Such differences could tentatively be hypothesised to reflect different aspects of social functioning, which in turn could suggest different attachment capacities, although more research is required in this area. Finally, it is useful to note that with the exception of one study (Tyrrell *et*

al., 1999) there is a male bias in all samples. This offers input into the debates regarding possible gender bias in schizophrenia (e.g. Ochoa, Usall, Cobo, Labad & Kulkarni, 2012) or attachment (e.g. Del Giudice, 2009; Bakermans-Kranenburg & van IJzendoorn, 2009) but may also limit direct comparison between studies given that the significance of this is yet to be fully understood.

Adult attachment, psychosis and symptomatology

Despite the limitations to the existing evidence, the current literature still offers some valuable areas of insight and discussion. In line with the wider clinical and analogue literature (Dozier *et al.*, 1990, 1991, 1999; Dozier & Tyrrell, 1997), the review supports the idea of there being a predominance of insecure related patterns of attachment found within a clinical population with psychosis, although discrepancies became evident at a more detailed level of attachment patterns and symptoms. These discrepancies may be the result of the aforementioned variance in the operationalization of attachment assessment or symptom diagnosis and definition, where researchers may not be referring to a consistent and comparable set of constructs. However, there is also the possibility that attachment style may not be directly predictive of symptoms and may involve a more complex, mediated route. Indeed, the idea of a single-pathway model is hard to theoretically reconcile with the large proportion of individuals with insecure styles of attachment that do not go on to develop symptoms or a clinical disorder.

The idea of the relationship between attachment and symptoms of psychosis being a mediated one has indeed been explored from a number of different theoretical perspectives in the literature. Within more recent cognitive models of psychosis such as that proposed by Bentall and Fernyhough (2008) for example, it is proposed that insecure attachment may shape negative schemas regarding self and other which confer a vulnerability to psychosis-related symptoms through the mediating role of additional cognitive biases, such as jumping to conclusions and deficits in theory of mind. An alternative perspective offered by MacBeth, Schwannauer and Gumley (2008) proposes that it is the *interaction* between insecure attachment and the use of related interpersonal strategies (i.e. distancing / affiliating) that predicts

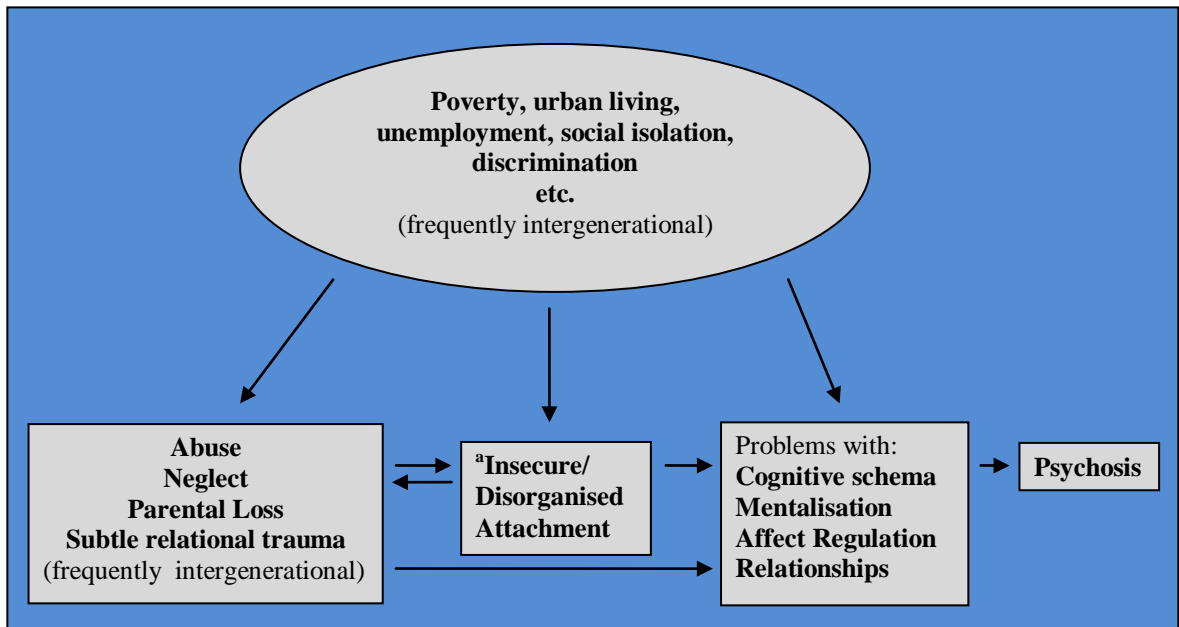
predisposition to psychosis-related symptoms. They highlight the potential relevance of social mentalities theory in underpinning their theory (Gilbert, 2001) whereby interpersonal processes are placed within an evolutionary context, but may become maladaptive in a contemporary setting. For example, the use of distancing or aggressive behaviours in response to a lack of ‘safeness’ and the activation of a threat appraisal system within someone with an insecure attachment style, may lead to increased hostility and isolation, perpetuating a sense of threat and lack of security and magnifying the vulnerability to paranoia.

Other potential mediating factors explored in the theoretical literature to date include emotion regulation difficulties associated with insecure attachment, and the role these may play in increasing sensitivity to social stress (Berry, 2007a). Also, the way in which dissociation and reduced mentalisation capabilities may mediate between early experiences of trauma and associated attachment disorganisation, dissociative responses and responses to stresses in adolescence and adulthood, leading to the development of psychosis-type symptoms (Liotti & Gumley, 2008).

A model proposed by Read and Gumley (2008, see Figure 2) captures a number of these factors, suggesting that attachment style can be viewed as a responsive adaptation to early environment, influencing (and being influenced by) cognitive schema, reflective functioning, affect regulation capabilities and interpersonal strategies. These in turn could impact on an individual’s social and personal resources for coping with stress, leading to vulnerability to psychosis. However, the ongoing uncertainty regarding the exact nature of some of these interactions is acknowledged, as is a requirement for further exploration into the types of adversity which may be differentially predictive of psychosis-related phenomenon, versus pathways to other disorders. Nevertheless, this model offers a useful conceptual framework for consolidating existing strands of research in the current literature regarding potential mediators between adverse experiences, attachment and psychosis, for example explaining why insecure attachment alone is an insufficient sole predictor of psychosis (*e.g.* Dozier, 1990; Pickering *et al.*, 2008). Furthermore, it is suggested that it has the potential to act as a focal point for developing and

testing hypotheses for future research, in order to generate a more sophisticated, in-depth and integrated understanding of mediated pathways to psychosis, currently absent in this field.

Fig. 2: Read and Gumley's (2008) model of the role attachment may play in the relationship between childhood adversity and psychosis.



^a Two- directional arrows indicate that insecure/disorganised attachment resulting from childhood adversity can increase probability of further abuse and neglect in later lifestages

Results from the first episode studies in the current review, along with the findings relating to service engagement, variation in symptom experience and recovery style, also suggest possibilities for further development of this model . Rather than viewing the onset of psychosis as a static end point, it may be valuable to acknowledge the complex, two-way interaction between an individual's experiences of psychosis and the attachment-activated cognitive, affective and interpersonal responses potentially triggered by these experiences (Gumley & Schwannauer, 2006). For example, an individual with an insecure pattern of attachment may have fewer resources for interpreting, coping with and adapting to symptoms of psychosis, with a less stable foundation of sense of self and other (Mulligan & Lavender, 2010). As such, the way in which the symptoms manifest themselves, and the *reaction* of the individual (and their significant others and health service responses) to these confusing and

potentially frightening early experiences, may activate and reinforce attachment states of mind, influencing onset, relapse and recovery pathways. Such an extension may also assist in making a distinction between aspects of pathways which are specific to the experience of psychosis and related symptoms, versus those which may relate to processes which confer a more generalised vulnerability to mental disorder.

A number of findings within this review also support the tentative hypothesis that a dismissing /avoidant or deactivating related attachment state of mind may confer an added vulnerability for poorer outcomes in a population with psychosis, relating to more chronic indicators, such as an earlier age of onset of illness (Ponizovsky *et al.*, 2007), longer periods of hospitalisation (Ponizovsky *et al.*, 2007), greater severity of symptoms (Berry *et al.*, 2009) and higher levels of distress (Dozier & Lee, 1995). This may be a factor of the more chronic nature of the symptoms experienced by these individuals, or poorer levels of service or professional engagement limiting outcomes (e.g. Kvrjic *et al.*, 2012a). A current absence of research in this area in relation to both individuals with psychosis or wider psychopathology and mental health services, suggests that this may be a fruitful area for further investigation.

The review also identified some findings, albeit not universally supported, relating to more frequent and threatening symptoms being experienced by those with an avoidant attachment style. Based on the pathways outlined by Goodwin (2003) it could be hypothesised that the interpersonal strategies adopted by those with deactivating coping styles could lead to the earlier development of psychosis due to the difficulty in establishing or making use of supportive peer networks, during the potentially stressful and critical period of adolescence (Sroufe *et al.*, 2000). The social mentalities model proposed by MacBeth *et al.* (2008) also fits with these findings, if it is assumed that avoidant attachment may be more readily associated with maladaptive interpersonal strategies of distancing and avoidance, leading to a greater risk of hallucinations and paranoia. Furthermore, it could be argued that the conflict created between an avoidance/dependence dynamic highlighted by this theory could be particularly significant in adolescence, a time when an individual

may still be forced financially, legally and culturally to be within a dependent framework. Liotti and Gumley's model (2008) whilst trauma-specific, does recognise the significance of avoidant/ dismissing styles of attachment in adulthood, relating them to avoidant and disorganised attachments in infancy. They suggest that negative symptoms associated with disturbances in interpersonal functioning and mentalisation in schizophrenia (e.g. 'social withdrawal' or impaired 'insight'), may be the result of an individual attempting to deactivate their attachment system, to allow them to cope with the intense fear and destabilisation associated with attachment interactions (Liotti & Gumley, 2008). This is supported by some of the findings in the review that demonstrate the lack of recognition, understanding and acceptance of emotional responses within an episode of psychosis amongst those with a deactivating coping strategy (Owens *et al.*, 2012).

The potential disconnect between clinician and patient-reported symptoms is also worthy of note within this review, with those associated with a hyperactivating attachment style reporting greater symptoms, but being considered less psychotic by clinicians than those with a deactivating style (Dozier & Lee, 1995). Again, this could be a complex yet useful area for further exploration, with a need to unpick the impact that different affect regulation and mentalisation capacities may play in the experience and acknowledgement of symptoms, as well as help-seeking attitudes. For example, individuals who are more avoidant may adopt minimising strategies to cope with the potential distress and conflict caused by symptoms experience, but may also be less prone to volunteer information which they feel is likely to increase the attention paid to them and pressure to engage with services. Equally, however, hostility and poorer capacity for social engagement may make it hard for a clinician to accurately assess an individual's symptoms, leading to an increased sense of severity of illness. Nevertheless, it is encouraging that potential distress experienced by individuals with an avoidant attachment style may not go unnoticed by professionals, despite barriers to self-reporting.

Interpersonal problems and social functioning

Despite the fundamental, relational nature of attachment theory and the growing recognition of its potential value in relation to formulating psychosis-related disorders (Berry *et al.*, 2007a), the review confirms that this continues to be a neglected area of focus. The demonstrated relationship between insecure attachment and greater severity of interpersonal problems is consistent with expectations. However, the associations between attachment anxiety and interpersonal deficits are perhaps more surprising given a hypothesis that avoidant attachment may also be heavily related to significant interpersonal challenges. This effect may be due to a reporting bias (*e.g.* attachment anxiety report higher prevalence of problems), variations in insight or the possibility that avoidant strategies may reduce the impact of, or exposure to, interpersonal problems. For example, an avoidant style of relating may reduce opportunities for hostile interactions and/or offer a protective sense of self-reliance which prevents conflict from being viewed as problematic. However, again such hypotheses need further investigation.

Attachment relationships within a mental health service context

The results of the review contribute to the debate as to whether professional supports within services can act as attachment relationships, demonstrating that insecure patterns of attachment can extend across to this relationship domain. However, it also highlights that not all relationships may activate attachment states of mind with the same level of intensity, with general relationships appearing to generate higher levels of attachment anxiety and avoidance compared to mental health keyworker relationships. It could be argued that this may be a research effect, where participants feel less able to be open about keyworker relationships within service-driven research. However, an alternative possibility is that the keyworker relationship may be qualitatively different in some way, either through being less faceless and potentially threatening to an individual than the vaguer concept of a 'general relationship', or conversely being less significant to an individual, thus activating lower levels of attachment behaviours. Schuengel and van IJzendoorn (2001) critique the assumption that service relationships are all attachment based, arguing that there may be criteria to be met before a relationship with a member of psychiatric staff

qualifies as such, mainly that the professional is consistently used as a secure base. This may be the case for secure attachment formation. However, findings in this review showing the increased attachment activation surrounding general, rather than specifically identified relationships (e.g. Berry *et al.*, 2007c; Arbuckle *et al.*, 2012), may start to offer an alternative argument, namely that the activation of the attachment system and resultant interpersonal strategies may occur more readily within novice relationships, where individuals may impose a generalised internal model of a threatening, unknown ‘other’. This could lead to insecure attachment strategies being more evidence at the beginning of a relationship, where failure to attend appointments, erratic presentation or difficulties in initial engagement may be more prevalent. Again, whilst there is a small amount of evidence showing greater rejection of service providers and poorer use of treatment amongst individuals with avoidant attachment patterns in the psychiatric literature (e.g. Dozier, 1990), and a small number of studies in the wider health literature supporting the links between avoidant style attachment and missed appointments (e.g. Ciechanowski *et al.*, 2006), a more in-depth longitudinal exploration of a journey of engagement for individuals with avoidant styles of attachment may be of value.

Whilst the idea of insecure avoidant styles of attachment and poor service engagement may be viewed as a barrier for services, there is less explicit consideration of the additional problems that may arise from attachment needs and bonds being formed within this environment for both patients and staff. Services may present as a relatively unstable relationship ‘partner’ with which to engage, with changes in personnel, structure, service delivery environment and protocol being relatively common events (Goodwin, 2003). Equally, bonds with patients may take a toll on staff, leading to burnout or preventing an objective stance being taken on care planning, interpersonal resolution and conflicting ward dynamics. Added to this, patient to patient attachments formed within services may also be fragile to maintain in the face of fluctuating mental health, service transitions and changing personal circumstances.

There is also some support from studies in this review regarding an association between poor service engagement and insecure patterns of attachment, although again this was not universally found. The components and processes implicated in the engagement process are not yet fully explored or understood, particularly in relation to the interactional nature of this concept, taking into account staff attachment patterns and service protocols (Goodwin, 2003). For example, the absence of an anticipated relationship between reflective functioning and service engagement difficulties in a FEP sample (MacBeth *et al.*, 2011) raises questions whether this lack of effect is general to all populations with psychosis, or whether alternative service engagement mechanisms may override the effects of reflective functioning on engagement in FEP populations (*e.g.* compensatory family involvement).

Only one study in the review considered including an assessment of staff attachment states of mind when looking at relationship dyads within services (Tyrrell *et al.*, 1999). Whilst being limited in its consideration of secure to insecure comparisons of professional-patient interactions, the finding that for deactivating clients in particular, staff attachment style can influence the strength of working alliance and possibly therapeutic outcomes, is an area that is of potential significant clinical value for a hard to engage client group. In their study of a more general psychiatric population, Dozier *et al.* (1994), also found that regardless of client attachment, case managers who used preoccupied attachment strategies were likely to provide more intensive intervention than those case managers who had dismissive attachment state of mind. Furthermore, case managers who were securely attached were more able to reflect on transference within their relationship with a client, and offer an experience that may be non-complementary to a client's existing internalised working models. Thus, for example, they may be sensitive to dependency needs of those clients who are dismissing, and equally offer those who are preoccupied a stable, consistent but limited and boundaried framework for relating. In this way, they may avoid further cementing insecure attachment strategies, such as discharging an avoidant client due to a hostile or seemingly disengaged manner. This reinforces the view that staff attachment style can be important in relation to an individual's repertoire of support

strategies (Ma, 2007). The discrepancy in staff and patient reports of therapeutic alliance demonstrated by Owens *et al.* (2012), also emphasise the need to consider therapeutic alliance as a dynamic, interactional process, where both parties and perspectives need to be considered.

Implications for future research

The review offers additional support and validation for investment in future research in relation to psychosis and attachment and a number of further avenues for research are highlighted throughout the discussion. Given the growing awareness of the complexity of this subject, research needs to be carefully constructed, with detailed consideration given to factors such as sampling (gender variations, chronicity of psychosis, control group selection), psychosis-related symptoms (assessment techniques, detailed nature of symptoms, affective components) and assessment of attachment (relationship domain, methodology, categorical versus dimensional analysis), along with variations in life history and current functioning.

A specific area of interest which may be worth additional empirical consideration, is the issue of gender and attachment in psychosis, which was only looked at by a minority of studies in the current review (n=3). There is some support for the existence of gender differences in attachment in non-clinical studies, in relation to both child and adult attachment (*see* Del Giudice, 2009; Read & Gumley, 2008), with a skew in insecure attachment towards males being avoidant and females insecure preoccupied. However, this area remains controversial, with a number of studies failing to find such significance (Bakermans-Kranenburg & van IJzendoorn, 2009), and questions remaining regarding the sensitivity of gender effects to specific assessment methodologies used for measuring attachment (Baldwin & Fehr, 1995). To date, the extension of these debates within a clinical context has been limited, but further expansion of the evidence base in relation to attachment, gender and psychopathology could add a useful new dimension to this field.

The review also demonstrates that there is at present, limited exploration as to the specific features of attachment relationships, therapeutic alliance and service

engagement which may be particular to psychosis-related disorders, versus other forms of psychopathology. In the absence of contradictory evidence, given that insecurity of attachment is essentially a relational vulnerability and that it has been shown to be a prevalent feature of a number of severe mental disorders, it is unlikely that challenges with engagement are limited to psychosis-related disorders alone. However, further work looking at staff understanding of and response to psychosis-specific symptoms, and the expansion of research looking at possible differentiation of intra and interpersonal processes in psychosis may cast further light on this.

Clinical implications

In general, the findings from this review provide further justification for the growing interest shown in integrating attachment concepts into psychiatric care. An understanding of individual attachment states of mind has the potential to help services predict ease and response to service engagement, and guide service responses in a way which may optimise the chance of maintaining treatment. In addition, it may contextualise the way in which an individual may use, or fail to use, interpersonal networks, in relation to accessing help, support and validation. An attachment-based formulation has the potential to offer a useful framework for capturing the inter-relating elements of an individual's presentation, including the way in which an individual experiences and responds to symptoms, developmental history and trauma, current mentalisation deficits, emotion regulation problems, social functioning limitations and service usage difficulties. This may provide a valuable tool for helping clinicians to understand and support complex, and challenging, individuals.

The idea that service engagements can act as attachment relationships also can assist with more individualised and considered service responses and intervention plans, and raises a possibility for useful therapeutic change (Ma, 2007; Berry & Drake, 2010). This may include the need for greater staff awareness of the way in which their own attachment behaviours may affect or limit their engagement with others. Whilst there are significant practical, personal and political sensitivities around formal assessment of staff attachment styles, increasing awareness of the relevance

of personal attachment styles can offer staff a framework for thinking about maladaptive responses to stress, their own use of support and ways of maintaining their own mental health (Mallinckrodt, 2000; Berry & Drake, 2010; Goodwin, 2003). This is particularly relevant given that mental health professionals may be relied upon as a secure base for others, as well as needing some flexibility of response strategies to attempt to promote alternative internal working models of relating within the patients they are supporting (Ma, 2007).

Limitations of the Review

There are a number of limitations to the current study which are useful to consider. Firstly, due to the non-availability of translation resources, the study only included papers in English. To assess the extent to which this may have influenced the review, a post-hoc check was carried out by the author using one of the larger databases in the initial search strategy (i.e. PsychINFO). A review of abstracts highlighted no further studies which met the criteria for the review. The review also included only articles published within peer-reviewed journals, in an attempt to increase the quality of study included in the analysis. This may have introduced a publication bias, given that studies with non-significant, or null hypothesis outcomes may be less likely to be published (Pettigrew & Roberts, 2006). Again, the author attempted to reduce this bias by contacting key authors included in the review, to ascertain the existence of any further relevant unpublished studies.

Conclusion

In summary, the current evidence base looking at attachment and psychosis is still in its relative infancy. There is a continued need for longitudinal studies in this area to narrow down patterns of cause and effect, and an expansion of findings regarding the complex pathways involved in the development of the disorders, and the way in which symptom development, service structures and attachment systems may be of mutual influence. Nevertheless, there remain some important findings in this field

that stimulate confidence in the relevance of attachment theory to adults with psychosis. It is hoped that a continued growth of interest in this area can offer clinicians and services increasingly sophisticated insights into optimum routes for support and intervention for individuals affected by this distressing disorder.

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Thesis Aims

The aims of the thesis are as follows:

Primary Aims:

- To develop an experiential account of help-seeking amongst individuals with chronic psychosis.
- To generate a grounded theory for the processes involved in shaping help-seeking orientation in mental health services amongst this clinical group.

Secondary Aim:

- To explore the ways in which constructs of individual attachment style, service attachment, recovery style and personal beliefs about illness relate to help-seeking in chronic psychosis, as defined by emergent categories and grounded theory from participant narrative accounts.

Journal Article (1)

“Sharing the burden”? A grounded theory of the experience of help-seeking within mental health services for individuals with a chronic history of psychosis.

Abstract

Introduction: Help-seeking in populations with psychosis has attracted increased attention over the past decade. However, there is little research in this field for individuals with a more chronic history of psychosis, despite the potential significance for relapse prevention and recovery.

Objectives: The aim of the research was to develop an experiential account of help-seeking amongst individuals with chronic psychosis, and generate a grounded theory for the processes involved in shaping help-seeking orientation in this clinical group.

Method: A social constructivist version of grounded theory was used for this study. Nine adults with a chronic history of psychosis were interviewed about their experiences within rehabilitation services. Narratives were transcribed and analysed within the framework developed by Charmaz (2006).

Results: The overarching theoretical concept emerging from this study was the significance of help-seeking as a relational construct for individuals with chronic psychosis. Orientation to help-seeking was shaped by an individual’s relative view of ‘self versus other’, which in turn dynamically influenced and was influenced by an individual’s service experiences.

Conclusions: Inner experience and interpretation of external worlds may continue to present barriers for effective help-seeking and service usage for individuals with chronic psychosis, despite being perceived as already ‘in the system’. Service acknowledgment of these barriers, may present opportunities for the development of a shared framework of understanding and improved future engagement.

Keywords: Chronic Psychosis, Recovery, Help-Seeking, Service Engagement.

(Prepared for submission to ‘Psychology and Psychotherapy’ Theory Research and Practice. Some formatting complies with university guidelines for consistency across thesis).

Practitioner Points

- Service experiences and interpersonal interactions with professionals within longer-term mental health settings can continue to have a significant impact on orientation to help-seeking and help-acceptance for individuals with chronic psychosis.
- An individual's relative sense of self in comparison to others may play a crucial role in willingness and capacity to find common ground for engagement with mental health professionals amongst this population.
- An understanding of individual formulations regarding help-seeking orientation may be a useful starting point for building rapport, avoiding rupture and designing accessible and effective programmes of support within rehabilitation services.

Introduction

Help-seeking within mental health services

Within the UK, drives towards community-based psychiatric care and a growing recognition of the inadequacy of pathways into mental health care have highlighted the need for a more informed consideration of barriers to help-seeking and service engagement within services (Singh & Grange, 2006). Rickwood & Thomas (2012) define help-seeking within a mental health context as ‘an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern’ (p.180). They propose that this can be divided into an individual’s orientation towards help-seeking (*i.e.* attitude), their intentions to seek help as well as their carried out actions of help-seeking.

To date, literature on help-seeking in mental health services has primarily been developed amongst general population samples with generically defined mental health problems. Fewer studies have taken a diagnostic-specific approach to the topic (Rickwood & Thomas, 2012).

Help-seeking and psychosis

A longer duration of untreated psychosis in first episode psychosis (DUP) is a well established risk factor for poorer clinical outcomes and recovery prospects (McGlashan, 1999; Marshall *et al.*, 2005; Perkins, Nieri, Bell & Lieberman, 1999). Consequently, studies which have looked at help-seeking in psychosis have predominantly focused on this population. Risk factors found to be associated with prolonged DUP have included poor insight, preserved coping skills, social isolation, fear of stigmatisation, insidious mode of onset, the presence of negative symptoms and family belief systems (*e.g.* Boydell, Gladstone & Volpe, 2006; Compton, Chien, Leiner, Goulding & Weiss, 2008; Drake *et al.*, 2000; McGlashan, 1999; Singh & Grange, 2006).

Help-seeking beyond ‘first episode’ psychosis

To date, there has been little, if any, direct attention paid to extended patterns of help-seeking amongst individuals with a more chronic history of psychosis, despite

the importance of ensuring timely and effective service response for these individuals. Cumulative rates of relapse and associated traumatic experiences of inpatient admissions have been linked to downward spirals of recovery outcomes (McGlashan, 1988; Robinson *et al.*, 1999). Furthermore, within the UK, policies continue to promote community models of long-term care for individuals with chronic mental health conditions (The Scottish Government, 2012; National Institute for Health and Care Excellence, 2010). Therefore, the need to address difficulties in help-seeking and service engagement amongst this population may increase in prominence.

Individuals with a long history of psychosis may present a unique set of issues with relation to help-seeking and service engagement, which warrants further exploration. Whilst there is growing recognition of the often traumatic impact of hospital admission for individuals with psychosis (Gumley & Schwannauer, 2006), little is known about the cumulative impact of these experiences on an individual's willingness and capacity to relate to the mental health system. Furthermore, factors commonly acting as barriers to help-seeking in first onset populations, such as impaired social functioning and fears of stigma (Boydell *et al.*, 2006; Drake *et al.*, 2000) may remain significant for those with more chronic psychosis, without an understanding of how this affects service long-term service engagement.

In summary, there is a valid clinically driven need for an extension of the literature to consider factors influencing help-seeking amongst individuals with a more chronic history of the disorder.

Aims of the Research

The aims of the research were to develop an experiential account of help-seeking amongst individuals with chronic psychosis, and subsequently generate a grounded theory for the processes involved in shaping help-seeking orientation amongst this clinical group.

Method

Methodology

A grounded theory framework was used for this study, due to its capacity to extend the analysis beyond exploration alone, and its relevance for generating an explanatory theory of a relatively unexplored phenomenon (Birks & Mills, 2011). A social constructionist version of this methodology was followed (Charmaz, 2006), acknowledging that narratives and meaning were co-constructed between researcher and participant. This was felt to be of particular importance given the recognised ‘staff member-patient’ roles held by researcher and participant.

Quality in research

The author followed quality criteria based on that of Birks and Mills (2011), to ensure sufficient rigour in conducting this research. This included considerations of researcher expertise, methodological congruence and procedural precision. A number of measures were put in place to address these elements, including the use of reflective memos, project planning and ongoing supervision to encourage self-awareness, clarity of purpose and sustained adherence to a grounded theory process.

Reflexivity

Charmaz (2006) emphasises the importance of making explicit the way in which the researcher’s own history, interests and assumptions may shape the research. The researcher was a UK clinical psychology trainee, completing this study as part of a qualification for a Doctorate in Clinical Psychology. Interest in this research area was generated over four years clinical experience working with individuals with psychosis, recognising the spectrum of poorly understood service engagement issues present in this client group. The researcher’s personal philosophical stance was most closely aligned to a critical realism perspective (Bhaskar, 1989), which accepts the existence of an objective reality independent of our thoughts which may motivate knowledge acquisition, yet also recognises that the description of reality is mediated through filters of language, social context and meaning (Oliver, 2012).

Sensitivity to context

The Royal Edinburgh Hospital (REH) rehabilitation service offers support to adults with longer term mental health needs across four adult rehabilitation wards, as well as community input for individuals discharged to supported accommodation. Participants were likely to have extensive experience of mental health services, including both community and inpatient services. They were made aware that the researcher was a psychology staff member in NHS Lothian.

Data collection

An open-ended, intensive interviewing approach was used for data gathering. An interview guide was developed for prompting and to encourage adherence to open-ended questioning (Charmaz, 2006). However, interviews remained flexible to allow emergent themes to be pursued. Interviews were opened in the same way, asking participants to describe the current sources of help that they receive in their life at present, and their views of these supports. The factual nature of this question was selected to put participants at ease and build rapport at the start of the interview.

Inclusion/ Exclusion Criteria

Individuals were considered eligible if they were service users with a primary, psychosis-related diagnosis and a history of at least two relapses of psychosis, along with sufficient capacity to consent to the study. Those with a formal diagnosis of personality disorder were excluded from the study, given the unique additional issues that help-seeking could present for this population.

Procedure

Study approval was granted from the West of Scotland Regional Ethics Committee 01 (Reference:12/WS/0144).

Recruitment

Potential participants were identified by named consultant psychiatrists and keyworkers within the rehabilitation services, and were provided with initial written information on the study. Those who expressed an interest in the study met with the

researcher and written consent was collected. Interviews were carried out in private, either on the ward or in participants' homes. These were recorded and transcribed by the researcher. A review of medical records was carried out for each participant, to obtain details of formal diagnosis and number and nature of previous hospital admissions. Sampling was reviewed following analysis of each set of three interviews, to assess the need for any specific purposive sampling strategy. This led to an emphasis being placed on the recruitment of individuals with a longer inpatient history within the final phase of recruitment, to allow an exploration of the negotiation of power dynamics within a structured service environment, which was emerging as an important element of the analysis.

Details of Participants

A total of nine individuals participated in the study. A summary profile is provided in Table 1. All participants were White British with a mean age of 50.4 years.

Table 1: Overview of study participant characteristics.

Participant Reference (gender)*		Age range**	Diagnosis	Service	No. Inpatient Admissions (Type)
P01(m)	<i>Phil</i>	30-40	Schizoaffective disorder	Community	10 (9 detained, 1 voluntary)
P02(m)	<i>Geoff</i>	60-70	Schizophrenia	Community	At least 7 (all voluntary)
P03(f)	<i>Suzie</i>	40-50	Schizoaffective disorder	Inpatient	25 (12 detained, 13 voluntary)
P04(m)	<i>Derek</i>	40-50	Paranoid schizophrenia	Community	8 (at least 4 detained)
P05(m)	<i>Ross</i>	30-40	Paranoid schizophrenia	Community	7 (all voluntary)
P06(f)	<i>Anna</i>	50-60	Paranoid schizophrenia	Community	20 (all voluntary)
P07(m)	<i>Jimmy</i>	50-60	Schizophrenia	Community	17 (at least 2 detained)
P08(m)	<i>Matthew</i>	60-70	Paranoid schizophrenia	Inpatient	26 (14 detained)
P09(m)	<i>Hamish</i>	50-60	Schizophrenia	Inpatient	4 long term (at least 1 detained)

* Pseudonyms provided only.

**Age range only given for purposes of preserving anonymity.

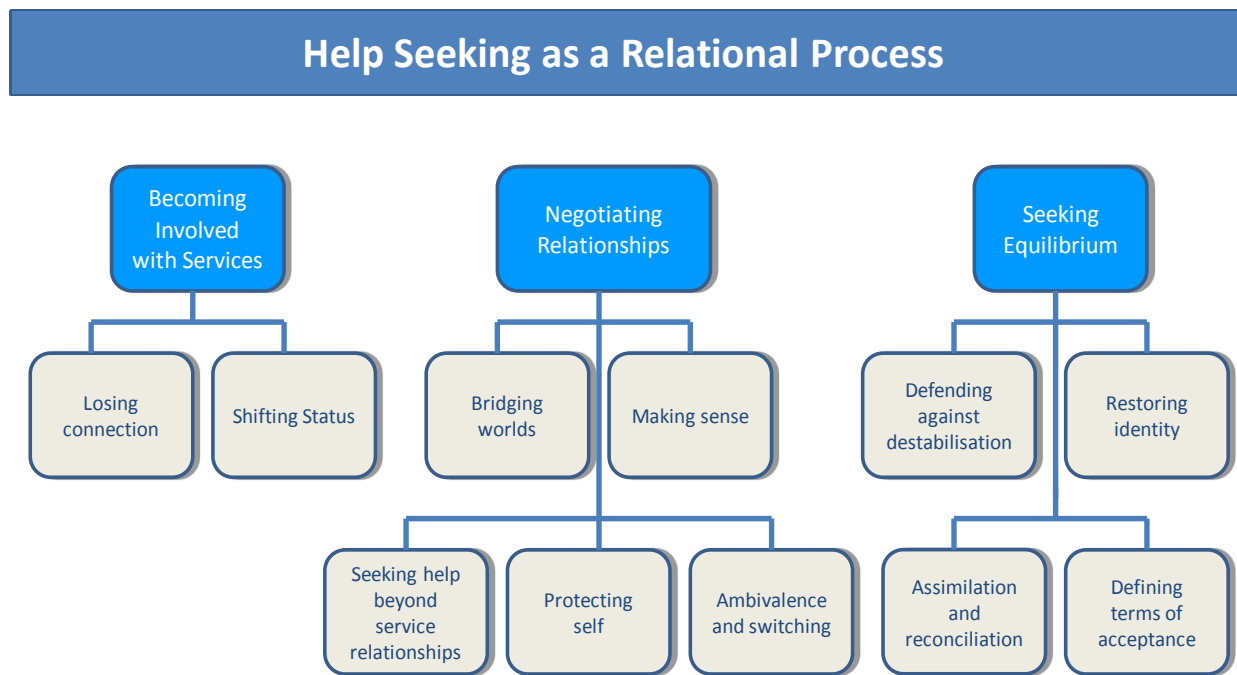
Analysis

Transcripts were analysed using line by line coding, which were raised to focused codes and tentative conceptual categories. This process was assisted by the use of memos and constant comparative analysis. Diagramming, post-it boards, spreadsheets and QSR International's NVivo-10 qualitative data analysis software were used to organise the data. Emerging categories were repeatedly overlaid back on the original transcript data, to add depth and richness to the emergent constructs and identify contradictory accounts. This process was repeated until it was considered that 'theoretical sufficiency' had been achieved, where categories appeared to adequately accommodate new data (Dey, 2007).

Results

The overarching theme emerging from this study was ‘help-seeking as a relational process’. Within this, eleven process categories were identified which were viewed as impacting on help-seeking attitudes. These were grouped into three stages, i.e. ‘*becoming involved with services*’, ‘*negotiating relationships*’ and ‘*seeking equilibrium*’. A diagrammatic summary of category organisation is provided in Figure1.

Fig 1: Summary of the process categories emerging from the grounded theory analysis



The three stages were loosely viewed as temporally organised, either within the course of a single episode, or over a longer arc of recovery. For example, participants appeared to describe experiences where processes associated with ‘negotiating relationships’ were more dominant, prior to engaging in those associated with

‘seeking equilibrium’. However, movement between the stages was not necessarily linear and individuals moved back and forth between process categories, or returned to previous stages, sometimes within the context of relapse, a difficult service interaction or the reactivation of affect during attempts to accept or reconcile experiences.

Help-seeking as a Relational Process

The core conceptual theme emerging from this analysis was that help-seeking was defined by participants within a relational context. In other words, individuals did not make help-seeking decisions in isolation of the wider social environment, but instead conceptualised it within highly personal frameworks of implications for the ‘self’ in relation to ‘others’ (i.e. ‘what does it mean about *me* if I am seen as needing or accepting help from *you*’). An excerpt from a memo (Appendix D) provides an insight into the development of this construct.

Becoming Involved with Services

‘Becoming involved with services’ was the stage at which entry into the mental health system, or increased involvement of services, occurred in response to psychosis. This emerged from retrospective accounts of first onset, but also for some at later stages of relapse, rehospitalisation or increased level of service intervention.

Losing Connection

‘Losing connection’ emerged as a process of being without a framework for understanding for the self, others and the world, in the face of unfamiliar and shifting inner experience during the onset of psychosis. This also led to disconnection with others, in the absence of any shared language for explaining and seeking help for experiences. At first episode, participants described a lack of understanding about what was happening to them, with no previous reference points for contextualising their experiences. This made it difficult to communicate experiences, inhibiting help-seeking and promoting fear and withdrawal. Early attempts to seek help from professionals, if made at all, were tentative and met with a response which failed to connect with an individual’s inner experience.

"I went to my GP and I said something like 'I've not been sleeping well and been really worrying about myself' ...I kind of expected him to respond. I think he just said... 'well it's probably just nerves about being in first year university' or something" (Phil, P01).

At this time, family could become a base to return to, either as a source of sanctuary and normality or as a desperate last resort.

'Losing connection' was still relevant at relapse, but it was less likely to go unnoticed by others once 'in the system'. Help-seeking was aided if a shared language for initiating conversations about relapse had been developed with staff, or family members.

"My mother said 'well you're getting agitated', and she would say 'go up to the hospital'" (Matthew, P08).

Shifting status

'Shifting status' referred to the described impact that service involvement had on an individual's sense of social status. This process was particularly evident in participant's retrospective accounts of first onset, where distress appeared to have reached acute levels before receiving professional service response. For some, eventual intervention was intensive and not viewed as 'receiving help', instead it was associated with fear of the unknown and a sense of diminished social status, particularly if an individual was sectioned and a power hierarchy made transparent. This could lead to withdrawal or a resistance to willing engagement with services. These episodes also had the potential to cause rupture with previous supportive external networks, particularly when family were seen as collaborating with services.

"And then they took me they took me into hospital. And..I said to my father I said erm you've betrayed me and my father said ..'Oh Hamish don't say that'..." (Hamish, P09).

However, for three participants, the acquisition of a 'patient status' appeared to also bring benefits of feeling 'safe' and 'looked after'. For these participants, it appeared

significant that they had already experienced a sense of threat and powerlessness in their external environment, prior to admission.

Some individuals continued to re-experience some shift in status if service intervention was intensified, for example at relapse. However, there appeared to be some capacity to counter this if admission was more collaboratively positioned.

Negotiating Relationships

‘Negotiating relationships’ was viewed as a stage of flux, whereby individuals attempted to make sense of their position within the service environment relative to staff and others, and their stance towards the role of ‘being a patient’.

Bridging Worlds

‘Bridging worlds’ referred to individual’s attempts to manage the interface between inner experience and external events, and its resultant impact on help-seeking. Service interventions in many ways instigated this process, requiring individuals to attempt to externalise their inner world, for example through assessment or therapy interactions. For some, this process facilitated help-seeking, allowing individuals to form some dialogue with professionals (*e.g.* reassurance seeking, reality checking), or was viewed as “sharing the burden” (Anna, P06). However, the difficulty in connecting “reality and non reality” (Hamish, P09), added uncertainty to help-seeking interactions, and some had little sense of others being able to connect with their inner world.

“they don’t seem to have the mindset to understand what I am going through you know”
(Jimmy, P07).

When no common ground could be established between inner experience and external service perspectives, individuals appeared to either accept service explanations to “*play the game*” (Matthew, P08), abiding by perceived rules of the hospital in the hope of avoiding conflict, or became withdrawn and dismissing of intervention. Internal uncertainty about experiences seemed to present a greater

opportunity for collaboration in developing a mutually acceptable explanation (e.g. Anna P06, Phil P01).

Making Sense

‘Making sense’ was defined as the process of attempting to form a template for relating to professionals. This encompassed additional contributory processes such as establishing boundaries, identifying limitations, recognising power differentials and revising assumptions. This process could extend across a long service history, although the impact of early service experiences appeared particularly significant.

For some, ‘making sense’ resulted in the development of a new, positive template of relating compared to previous experiences.

“I’m going to accept support for as long as I can because a) they are like friends, b) they don’t bring me alcohol and c) they don’t bring drugs and they don’t want to have sex with me which is like you know thank god and ...they are there when I need them” (Ross, P05).

However, for others, the lack of clear boundaries and definition of service-user / staff relationships could trigger a painful sense of rejection, humiliation or embarrassment if relationships were misinterpreted. At this point lines were drawn and staff status became more overt. Participants remained acutely attuned to how they may be perceived by professionals at a more personal level following such conflict.

I felt like I entered a kind of relationship with mental health that was ...like I was some kind of pariah.....like I had done a great deal of..I don’t know.....it was just like a kind of relationship where people felt ...antagonistic towards me...not face to face, face to face the relationship was that we could work through it” (Phil, P01).

Seeking help beyond service relationships

‘Seeking help beyond service relationships’ recognised that some individuals, even when in intensive service settings, failed to classify staff supports as a primary source of help. Instead, they viewed help as coming from non-mental health orientated activities (e.g. shopping, poetry), physical environment (e.g. landscapes),

significant relationships outside the system (*e.g.* family) or in the case of two participants, super-ordinate forces (*e.g.* Jesus Christ).

"So err for me now, Christ is my doctor. He's the one I get support from, not from the staff." (Derek, P04).

For some participants, this rejection of the idea of needing help from staff also generalised to interpersonal relationships in general.

"I sometimes doubt that [other people can give help]...cos I tend to get the feeling of people as being...callous" (Hamish, P09).

Protecting self

'Protecting self' captured the process whereby some individuals adopted strategies to protect themselves from perceived threats directly attached to help-seeking in the mental health system. These threats included being seen as 'not coping' thus prolonging hospital admission, being seen as a burden or troublemaker, being given unwanted medication or alternative intervention, exposing vulnerability, losing face, being dismissed or having unhelpful intrusion into inner experience.

"I have been medicated you know...they want someone that's not a zombie..but somebody that's ... calm all the time. I'm still in inner turmoil inside myself...but I control it..." (Matthew, P08).

"I don't want people hearing me crying cos they might ...I don't want people to know how deeply I am affected by emotions and things" (Ross, P05).

Ambivalence and Switching

'Ambivalence and Switching' referred to the discomfort and uncertainty expressed in some accounts regarding a personal need for help, and the implications this had for the self. A number of individuals were both dismissive of their need for help but also hesitant about their capacity to manage without services, and appeared to develop a range of strategies to cope with this dissonance. These included distancing themselves from past episodes of 'help-receiving' and blaming their vulnerability on

transient circumstances, medication or physical ill-health. Others framed help-seeking as a way of knowingly working the system for personal gain. Some individuals attempted to address their uncertainty by using others as a ‘mirror’, either for a direct reflection (*e.g.* asking family or keyworkers to comment on their wellness), or used more subjective, generalised and possibly distorted comparisons.

“Just a lot of the patients that are here they are all totally mad.....I’m the only normal person on the ward do you know what I mean.” (Suzie, P03).

Seeking equilibrium

A final stage that emerged from the analysis described the attempts of some to reach a place of ‘equilibrium’, a personal stance or position which allowed them to accept or compensate for changes experienced as a result of illness-related experience.

Defending against destabilisation

‘Defending against destabilisation’ referred to the adoption of strategies to defend against perceived threats for relapse. These strategies could be developed collaboratively with services, particularly when a mutually acceptable understanding of an individual’s experiences had been formed (*e.g.* relapse-prevention plans). In other cases, however, internally held beliefs about destabilisation were not in tune those of service perspectives, potentially causing confusion and conflict on both sides. This was shown in Ross’s description of why he avoided self-care, which for staff was seen as a sign of relapse.

“it seems whenever I start looking after myself ..you know physically...bad stuff starts happening... if I’m doing something good for myself someone else is going to do something bad to me.” (Ross P05).

Three participants (Ross P05, Phil P01 and Matthew P08) also viewed affect as destabilising and thus attempted to control this, often finding themselves overwhelmed by feelings of empathy and distress.

"I see people suffering in the world and the way I suffer myself...I just seem to kind of have an emotional reaction that is sometimes a bit stronger than other people" (Phil P01).

Assimilation and Reconciliation

'Assimilation and reconciliation' was defined as the process of retrospectively attempting to find a way to accept significant, emotive past experiences and illness-related loss. This process had the potential to influence present and future attitudes about services relationships and help-seeking.

"The more you start to live in the past I think, the more it comes through in the present and it sort of, it really complicates relationships and things....some things I wish I'd done differently so....I can understand why other people maybe wish things had happened differently as well". (Phil, P01).

"..you can grow from the experience, or let it strangle you like a weed. I've grown out of all proportion over the last 20 years...especially over the last 5 years with coping mechanisms with my illness." (Matthew, P08).

For some, this opened up opportunities for a more accepting approach to services and future help-seeking, as shown by Derek (P04) describing a past experience of being sectioned.

Well it was an unfortunate experience but now I don't mind them at all. I feel they are doing the right thing and I'm glad that they've done what they've done and I'm glad the way things have ended up the way they've ended up " (Derek P04).

However, for others, painful feelings as a result of losses appear to be directed towards services, potentially shutting down engagement, as demonstrated by Suzie (P03) reflecting on the death of her mother which occurred during the course of her illness.

"I just miss my mum so much, I hate this place" (Suzie, P03).

Restoring identity

‘Restoring identity’ was defined as the process of attempting to (re-)build a sense of self and identity, for example through future plans, relationships or roles. Some participants accepted help from services to meet these goals, others seemed to keep this process heavily partitioned from mental health care interference. Three participants had adopted meaningful roles for themselves within the service which appeared to carry a more positive sense of identity than being a patient. This included taking the role of ‘veteran’, a source of experience (Matthew P08, Jimmy P09), a ‘graduate’ returning to the ward for visits (e.g. Ross P05) or a ‘caregiver’ (Matthew P08, Jimmy P07).

“those two minutes of the day go by and you might put your hand out and go ‘high five’ and they’re [other patients] quite happy with that, just leave them with that you know” (Matthew, P08).

Defining terms of acceptance

‘Defining terms of acceptance’ related to an individual’s use of strategies to attempt to increase (or reinstate) some sense of personal control around help giving and receiving, thus establishing a more acceptable equilibrium with services. For some, this involved exerting choice in managing the portfolio of support they had built up during their time in services (e.g. when, how and whether to accept help from their supports), others ‘reframed’ or experienced relationships as more equal and collaborative.

This shifting and renegotiating of relationships was not necessarily one-way, and professionals were also experienced at adjusting their interactions over time.

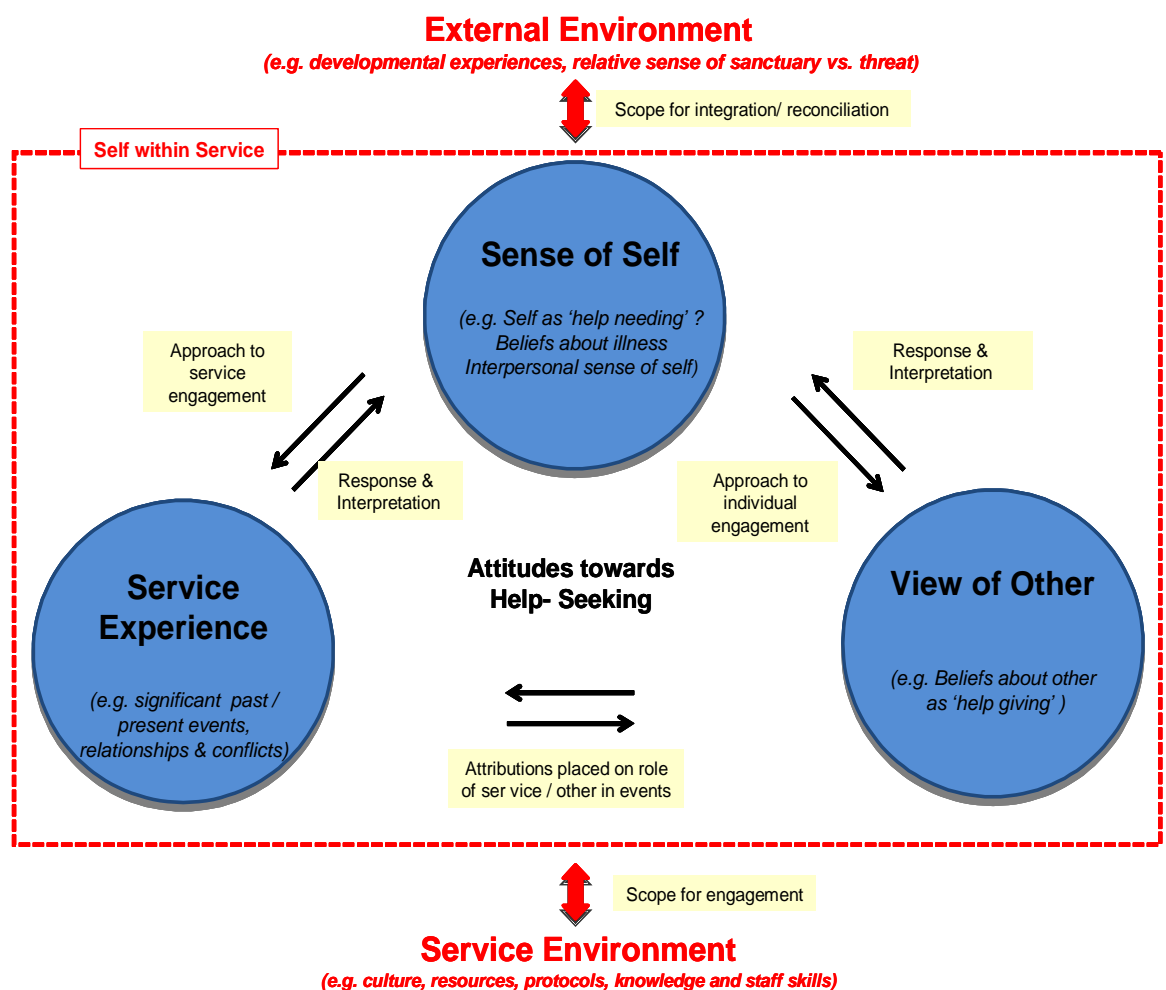
“It used to be very much..... how’s your mood and how are you feeling in yersel’, but most of the time now with [psychiatrist] it’s like ..’do you want a cup of tea ?’ ...we’re just you know shooting the shit” (P04, Derek).

Appendix I provides a summary table outlining the hypothesised barriers and facilitators for help-seeking and engagement associated with each of the process stages outlined in the analysis.

Summary of Grounded Theory

An emergent grounded theory summarising the influences on help-seeking attitudes for individuals with a chronic history of psychosis and mental-health service involvement is described in Figure 2. This was raised from the conceptual categories identified at data analysis, and was seen to apply to processes occurring at any one of the three stages identified in the analysis. Equally, process categories may sit within or across one or more of the three key domains highlighted in this model.

Fig. 2: Diagrammatic summary of grounded theory of influences on attitudes to help-seeking for individuals with a chronic history of psychosis.



Central to the model are three domains of influence that can shape an individual's views towards help-seeking in services. **Sense of Self** represents the extent to which an individual believes themselves to be vulnerable, the beliefs held about their symptoms, relapse and mental health, and their interpersonal view of themselves (*i.e.* as someone who is able to connect with others or not). **View of Other** refers to an individual's beliefs about a generalised 'other' and/or specific service relationships, including expected response and capacity for help giving, and view of the other as a source of threat. **History of Service Experience** refers to one-off or consistent, repeat experiences which are of significance to the individual (belief-reinforcing or dissonance-creating). This may include traumatic experiences or interventions (*e.g.* ECT, therapy, restraint, sedation). The three domains are viewed as interactive. For example, a significant service experience may impact on an individual's sense of self *and* the attribution made to others' role in this event. Likewise, deeply rooted beliefs about self may influence the way in which interactions with others and events are approached, experienced and interpreted.

The service-user's view of help-seeking is recognised to be influenced / limited by two external influences. **External Environment**, includes elements such as past and present relationships with significant others, and the presence of external threats (*e.g.* bullying). An individual's ability to integrate this external environment and inner experience, including the reconciliation of any ruptures or discrepancies, may influence help-seeking attitudes. **Service Environment** includes the way in which service culture, infrastructure and policy, and the impact this has on staff interaction styles, influences the system. An individual's ability to find some common ground with this environment may also shape help-seeking attitudes.

Discussion

The aim of the research was to develop an experiential account of help-seeking amongst individuals with chronic psychosis, and generate a grounded theory for the processes involved in shaping help-seeking attitudes amongst this clinical group.

Integration of findings with the existing literature

The discussion will focus on three specific areas of convergence between the emerging theory and the current literature; the enduring significance of first episode events in help-seeking, the relationship between help-seeking and attachment theory and the relationship between help-seeking and social rank theory.

The enduring significance of first episode events and help-seeking

Whilst stemming from participant's long-term, retrospective memories, the analysis in the current study reinforced the idea that factors such as stigma, withdrawal, mismatched service response, family mediation and emergency intervention, play a significant role in experiences of first onset and help-seeking (e.g. Addington, van Mistreat, Hutchinson & Addington, 2002; Bechard-Evans *et al.*, 2007; Boydell *et al.*, 2006; Compton, Chien, Leiner, Goulding & Weiss, 2008; Drake *et al.*, 2000; McGlashan, 1999).

The *enduring* significance that individuals placed on traumatic experiences within services, particularly in relation to first-episode events, fits with the ideas of Gumley and Schwannauer (2006) which propose that autobiographical memories of past service responses to psychosis-related experiences could play a significant role in activating intense negative affect and fears of, and vulnerability to, repeated relapse. There is some initial support provided from the results of the current study which is consistent with the hypothesis that a heightened sense of threat surrounding relapse, can trap some individuals in a cycle of fear, resistance and avoidance, which in turn could lead to deterioration in health and the need for increased service intervention.

"I've got to fit in with a lot of acute patients and I'm not acute....my fear is that I might become acute....because of the stress that I'm under you know...mostly err I fit in ok but its when the klaxons go off in here...I have no control – people running up and down the corridor I just have to go to my room.... I just get upset for the people that are upset cos I have been held down myself" (Matthew, P08).

Help-seeking and attachment theory

There has been recent interest in the psychosis literature regarding the association between attachment theory and help-seeking behaviour, and the role this may play in engagement, relapse and recovery (Blackburn *et al.*, 2010; Gumley & Schwannauer, 2006; Tait *et al.*, 2002). Within the grounded theory model emerging from this study, the emotionally laden domains of beliefs about self and other are consistent with the concept of internal working models of relating lying at the heart of attachment theory (Ainsworth, 1991). Thus, an individual who views themselves as not in need of help, and others as unhelpful (e.g. Derek, P04) may be enacting more dismissive-avoidant patterns of relating within services. Indeed, there is evidence that insecure attachment styles, particularly avoidant type, are more prevalent within populations with psychosis (Dozier & Lee, 1995; Kvrjic *et al.*, 2012; Ponizovsky *et al.*, 2007), particularly amongst chronic populations (Tyrrell & Dozier, 1997), which can lead to defensive strategies such as poorer service engagement and reduced self-reporting of symptoms, which may impede help-seeking.

The recognition of the importance of ‘service experience’ within the grounded theory model, and the strength of affect associated with processes experienced at the ‘enmeshment stage’, also converge with some debates in the field of attachment. Berry and Drake (2010) for example, highlight that events relating to entry in rehabilitation services can be associated with high levels of loss and insecurity. This in turn can trigger the attachment system, and related defensive coping strategies including possible hostility and withdrawal (*e.g.* Schuengel & van IJzendoorn, 2001). In the process of onset or relapse, attachment related patterns of self sufficiency can backfire if an individual’s resources become overwhelmed, leaving the individual with few alternative coping strategies (Wei *et al.*, 2005). A quote from the analysis offers some empirical support for this theory.

I think sometimes when you go through too much is that that you collapse and at that point you can say you need actual support but otherwise you wouldn't” (Derek P04).

The central attachment concept of a ‘secure base’ (Bowlby, 1982) also aligns with some aspect of this analysis, firstly in individuals described attempts to return to

family at times of threat, and secondly in supporting the idea that a service institution can be considered by some as a 'secure base' (Adshead, 1998) particularly in the face of threatening external environments.

A final area of convergence between attachment theory and the current study is the recognition that staff relationships can represent highly meaningful interpersonal interactions for individuals. The attachment literature is giving growing attention to the possibility of staff and service interactions serving as attachment relationships (Adshead, 1998; Ma, 2006, Goodwin, 2003), and there is some recent empirical support for correlations between attachment styles in personal and service domains (Arbuckle *et al.*, 2012, Berry *et al.*, 2007). This is again consistent with the personal significance of staff relationships to participants, as expressed in this study, and the intensity of affect experienced in response to incidents of perceived rejection and abandonment from staff. It is also consistent with the difficulties some experienced in trusting and engaging with staff, without feeling a heightened sense of vulnerability and threat.

Help-seeking and social rank theory

A third area of the psychosis literature which offers interesting comparison for the current study is social rank theory and help-seeking. Social rank theory (Gilbert, 2001) argues for the significance of evolutionary adaptive 'social mentalities' which shape inter and intra-personal emotional, cognitive and behavioural processes and responses in others. These may include reactions to change in social rank, assessment of threat and the formation of social alliances. Birchwood, Jackson, Brunet, Holden and Barton (2012), highlighted a number of specific dimensions associated with first episode psychosis embedded within a social rank framework, namely experiences of loss, entrapment, control, social marginalization and shame. Many of these are seen to be mirrored within the emergent findings of individual accounts for this study, and the identified challenges for help-seeking and engagement. Furthermore, it provides an explanatory framework for the importance of a restoration of status and independent sense of identity, as captured within 'seeking equilibrium'. However, this study again offers some possible extension to the debates in this field, proposing

that social mentalities may continue to be of significance in interpreting service interaction and engagement over a longer course of service experience for individuals with psychosis, and may help services negotiate more meaningful and motivating recovery plans for this population.

Clinical implications

The results of this study support the view that mental health services may benefit from increased recognition of the central importance of interpersonal status and relating to service engagement.

There is already a growing body of research looking at ways in which interpersonal dynamics, such as attachment states of mind, can influence client and professional therapeutic interaction and engagement on a one to one basis (e.g. Hardy *et al.*, 1999; Mallinckrodt *et al.*, 1995; Rubino, Barker, Roth & Fearon, 2000; Tyrrell *et al.*, 1999). This demonstrates that therapeutic outcomes extend way beyond an individual's response to intervention in isolation, and interpersonal patterns of relating of both the patient and therapist can influence the style and type of therapy delivered (Daniel, 2006). However, the implications of the current study extend beyond specific therapeutic interventions alone, emphasising the importance of daily relationship dynamics and service experiences for individuals in long term services.

By failing to recognise the potential significance of interpersonal dynamics between service and individual, the widespread application of standardised service protocols and pathways of care may inadvertently reinforce difficulties with help-seeking and acceptance, strengthening a 'them and us' culture (Birchwood *et al.*, 2012). Thus, for example, individuals who view themselves as helpless and others as helpful may initially fit comfortably within a service structure designed to 'provide help', allowing services to take a lead on intervention. However, in doing so, the relational beliefs held by an individual may be reinforced, and transitions such as reduction of support or staff changeovers may become particularly destabilising and traumatic for an individual. Over time, a lack of shift in dependency may also provoke frustration in staff, leading them to reduce pathways of support, further increasing an

individual's sense of vulnerability and fragility of service relationship. Conversely, individuals who have a more distancing and dismissive relationship with services may provoke a more rejecting or low effort response from others, again reinforcing the view of self and other.

Therefore, an understanding of individual formulations regarding help-seeking orientation may provide services with a useful starting point for building rapport, avoiding rupture and promoting a more consistently therapeutic response to an individual within a meaningful framework. For example, an understanding of Suzie's (P03), fear of help-seeking (*i.e. being seen as unwell thus prolonging hospitalisation*) may help staff increase her sense of safety for disclosure, as well as providing a more accurate insight into her inner experience at times when she withdraws. Furthermore, in line with the proposed model, being perceived as unwell may be threatening to Suzie (P03)'s sense of self and may be strongly defended if approached directly, suggesting services may more successfully engage with her using an indirect, normalising approach. Likewise, for Anna (P06), a greater appreciation of the stabilising role that having a 'safety net' (*e.g. staff support, hospital respite*) plays for her, may prevent services getting into spiralling patterns of relapse and recovery, when her perceived wellness leads to the removal of these supports, without a suitable alternative 'scaffold' being put in place.

Limitations of the study

Reflexivity Considerations

The theory emerging from this research was constructed from the researcher's interpretation of the data, and therefore only provides a starting point for further exploration. The researcher's personal experience of working with this client group and her training background, brought with them possible assumptions which could have affected the interpretation of meanings within the participants transcripts. For example, the researcher approached this study with a belief that a therapeutic environment extended beyond medication-based interventions, and indeed a number of those in longer term services often failed to manage their illness on medication

alone. Furthermore, from her own clinical experience and her awareness of the rehabilitation literature, she had beliefs that the hospital ward environment could feel unpredictable, prohibitive and threatening for some, and that individuals who were detained often wished to leave the hospital setting. The use of memos to make the researcher's position more explicit, and continuous reflection of the influence this may have on findings before during and after analysis, helped to increase confidence that these pre-existing assumptions were not restrictive to the interpretation of findings within this study.

Other limitations

It is recognised that the chosen methodology may have led to a theory which primarily addresses the conscious 'orientation' and 'intention' aspects of the help-seeking process (Rickwood & Thomas, 2012) rather than offering a direct prediction of an individual's actual behaviour. Further research would be required as to the degree to which these accounts reflected actual help-seeking behaviour.

In addition, the focus and design of this study generated a *service-user* perspective on help-seeking amongst a specific clinical group, and did not encompass dynamics experienced by the service provider, or necessarily represent individuals with more acute, short-term forms of psychosis. The researcher also recognises that recruitment challenges associated with studies amongst a more chronically unwell population (particularly the 'threat' associated with recorded interviews and paranoid beliefs), may have introduced some sampling bias. Furthermore, the researcher's own role as a staff member may have influenced willingness to talk openly about experiences. However, the emergence of concepts such as fear, threats, stigma and status within this research, and the triangulation of concepts with theories in the existing literature, could be viewed as offering some reassurance that individuals were able to disclose difficult experiences, and that narratives were not solely captured from individuals only with positive service relationships.

Future research

A useful extension of this research would be to explore the emerging processes of help-seeking amongst individuals with differing adult attachment styles, to identify whether this does indeed offer a significant framework for understanding this topic. The process stage of ‘seeking equilibrium’ also raises questions for further exploration, given the paucity of research amongst individuals with a much longer arc of service experience in psychosis. More in-depth understanding regarding the factors underpinning this process of change, may offer valuable insights into pathways to recovery for those with a more chronic history of psychosis. For example, within the current model, it could be hypothesised that a shift in interpersonal sense of self and other, an improved capacity to form a shared mutual framework of understanding or accumulated, positive service experiences may all promote a shift in help-seeking orientation. This could create avenues for expanding understanding and clinical intervention options for such individuals, rather than just accepting these individuals as being ‘revolving door patients’ (Haywood *et al.*, 1995) where future relapse is accepted as likely or inevitable.

Conclusions

Study findings suggest that difficulties with help-seeking in psychosis continue to be of relevance for those with long service histories. Orientation to help-seeking can be dynamically shaped by an individual’s relative view of self and interactions with services and professionals. The model proposed from this study may help expand thinking on how best to support recovery amongst a more chronic patient population.

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Journal Article (2)

Supplementary insights into help-seeking in chronic psychosis: Further development of a grounded theory model of help-seeking.

Abstract

Introduction: This study aims to explore the relevance of existing constructs of relating and adaptation to psychosis to the help-seeking orientation of individuals with chronic psychosis within mental health services.

Method: Nine adults with a chronic history of psychosis were given four standardised questionnaires assessing *adult attachment style*, *service attachment*, *recovery style* and *personal beliefs about illness*. Results were interpreted within the framework of a model of help-seeking in mental health services emerging from an initial, qualitative grounded-theory phase of the study.

Results: Particular synergies between self-reported attachment styles, levels of service attachment, recovery style and orientation to help-seeking were identified. Two refinements to the grounded theory model were proposed, the first placing an emphasis on the relevance of *interpersonal* context of beliefs about illness, the second acknowledging the potentially significant role that developmental based capacities may play in shaping service interaction and engagement. The need for large-scale, longitudinal studies in this field was highlighted.

Conclusion: Findings reinforced the significance of the relational emphasis underpinning the development of help-seeking orientation in individuals with chronic psychosis in mental health services. An understanding of an individual's personal and service attachment state of mind, along with their attitudes towards recovery, may provide an accessible way for services to formulate help-seeking orientation amongst this clinical group.

Keywords: Psychosis, Recovery, Help-Seeking, Service Attachment, Adult Attachment.
(Prepared for submission to 'Psychology and Psychotherapy' Theory Research and Practice).

Practitioner Points

- An awareness of an individual's adult attachment style, level of service attachment and recovery style may provide clinicians with practical tools for formulating and anticipating an individual's help-seeking orientation and opportunities for engagement.
- Flexible service response which is compatible with an individual's help-seeking orientation (e.g. seeking help from others versus self, people versus non-relational supports) may be a valuable way of initiating and maintaining engagement with individuals with more chronic psychosis.

Introduction

This article describes the second part of a study looking at help-seeking in mental health services amongst individuals with chronic psychosis. It specifically focuses on the way in which existing constructs associated with patterns of relating, service engagement and response to psychosis may influence, or provide insight into, help-seeking orientation in this population.

Meaningful service engagement and support is particularly relevant for individuals who have had distressing psychotic experiences given the significant burden this places upon an individual's psychological, affective and physical resources (Gumley & Schwannauer, 2006). Relationships between mental health service providers and service users have the potential to fulfil a number of important roles for this population, including a sense of safety, validation, acceptance and comfort (Goodwin, Holmes, Cochrane & Mason, 2003). However, the ability to access an experience of being helped may extend beyond service availability alone, also encompassing an individual's willingness and ability to accept help and capacity to engage in relationships with services (*e.g.* Goodwin, 2003), and professionals' response to this (Tait *et al.*, 2004).

An earlier article describes the development of a grounded theory model of help-seeking, generated from in-depth, qualitative interviews with individuals with psychosis within a long-term, rehabilitation service. This model highlighted three interacting 'domains of influence' which could shape an individual's orientation towards help-seeking within services, namely an individual's interpersonal *sense of self*, their *view of other* as a positive source of support, and their current and historical accumulated *service experience*. These are set within the context of past and present environmental influences, including service culture, infrastructure and practices.

The hypothesised model is suggested to have resonance with a number of relatively more established constructs within the psychosis literature. These include adult

attachment style, service attachment and psychosis-related factors within an interpersonal context, including approach to recovery and an individual's beliefs about their illness.

Adult attachment within services

Attachment style has been proposed to mediate individual's responses to psychosis, including their ability to form supportive relationships to prevent or manage relapse (Gumley & Schwannauer, 2006). It has also been highlighted as an important possible component of service engagement (Berry & Drake, 2010; Tait *et al.*, 2002). There is some empirical support for the idea of attachment relationships being formed with professionals within mental health services (Berry *et al.*, 2007; Arbuckle *et al.*, 2012). There is also some suggestion that mental health care institutions may have the potential to stimulate a more generic 'attachment to place', offering some sense of sanctuary (Goodwin, 2003) above and beyond one to one relationships.

The proposed model of help-seeking is hypothesised to have compatibilities with a number of elements of attachment theory, including the way in which inner working models of self and other (Ainsworth, 1991), may impact on an individual's relative sense of vulnerability and capacity to accept others as a non-threatening source of help. It may also shape the way that services are used and responded to, as well as influencing an individual's interpretation of past and current service experiences and ongoing orientation to help-seeking and engagement.

Recovery style

Recovery style has been found to relate to coping strategies and adjustment outcomes in psychosis (McGlashan, 1987). Individuals with an 'integration' style of recovery are perceived as being able to be more flexible and variable in the way they explore their illness, having curiosity about their symptoms and attempting to place these within some system of meaning relating to their past and present life. In contrast, individuals with a 'sealing over' style, are viewed as having more fixed, negative views of their illness and make fewer attempts to explore and find meaning for these experiences (McGlashan *et al.*, 1975). A sealing over style of recovery had been

proposed to lead to poorer social functioning and a more negative view of self and other (Drayton, Birchwood & Trower, 1998; McGlashan, 1987, Thompson, McGorry & Harrigan, 2003). Avoidant styles of coping (i.e. recovery style) have also been found to relate to insecure attachment style, and lower engagement with services (Adshead, 1998; Tait *et al.*, 2003).

Recovery style has the potential to shift over an individual's course of recovery from psychosis (Tait *et al.*, 2004). It is also seen as being independent from levels of insight or symptoms of psychosis (Drayton *et al.*, 1998, Tait *et al.*, 2003). A study by Tait *et al.* (2004) found that individuals were more likely to seal-over if they had a vulnerability to believing that others may view themselves more negatively. Therefore, it was their sense of self *relative to* their views of other that was key, not just the existence of negative beliefs alone. Furthermore, being able to develop some sense of identity which extended beyond illness also appeared to be a catalyst in more successful recovery. These are consistent with the principles outlined in the emergent model of help-seeking.

It may be hypothesised that individuals who are able to sustain a more positive relative sense of self and adopt an integration style of recovery, may have more capacity to establish a shared framework of understanding with staff, promoting a more positive orientation to help-seeking. This is particularly pertinent in the face of service models which often depend upon open discussion and confrontation of experiences and symptoms of psychosis within treatment. In contrast, those with a sealing over coping style may perceive service experience as more threatening and intrusive (Tait *et al.*, 2004) and may find less territory for being able to engage with rehabilitation programmes, thus impacting on their capacity and willingness to seek and accept help.

Appraisal of illness:

Birchwood *et al.* (2012) argue that beliefs and emotions following the onset of psychosis may represent a loss of social defeat and status, in line with social rank theory (Gilbert, 2001). This theory suggests that an individual's psycho-social

response to their environment may be heavily shaped by innate, evolutionary ‘social mentalities’ which have been adaptive in optimising reproduction and survival. Within the context of help-seeking, an individual’s beliefs about the degree to which their illness has impacted on their own social status and relative sense of self, could have a significant impact on the way in which they respond to a help-giving system. For individuals with more chronic psychosis this picture could become more complex. Repeated voluntary or involuntary service immersion could lead to a sustained experience of loss of status, although it could conversely be argued that prolonged service experience could also present alternative opportunities for rebuilding alliances and gaining an increased sense of control.

The aim of this study was therefore to offer an initial exploration of the synergy between a proposed grounded-theory model of help-seeking in services amongst individuals with chronic psychosis, and additional participant characteristics relating to constructs of relating, recovery and beliefs about psychosis.

Methodology

A more detailed description of the methodology for the social constructionist, grounded theory component of this study is given in a separate article. Therefore, information provided here relates primarily to the questionnaire component of the study, and issues relevant to the integration of qualitative and quantitative methodologies.

Design

The overall study design was most closely aligned with an ‘embedded mixed-methods’ approach, with primary emphasis on the qualitative element of the research (QUALquan; Creswell & Plano Clark, 2007, p.85). The qualitative component of the study used a social constructivist, grounded-theory based methodology. A secondary, quantitative set of data was gathered using standardised questionnaires. Data was collected concurrently, but only integrated following qualitative analysis.

Rationale

The addition of a questionnaire-based element to this study was considered a means by which categories and grounded theory constructed from the qualitative element of the project could be contrasted against existing theoretical constructs in the psychosis literature. This offered a more structured approach to triangulation of emergent theory, and allowed a more in-depth consideration of the way in which potentially relevant constructs in the literature may have influenced individual narratives (Cresswell & Plano Clark, 2007).

Epistemological compatibility

The epistemological stance of ‘critical realism’ (Bhaskar, 1989) adopted by the researcher within this study, has been argued to have a good fit with research in social science (Oliver, 2012). This philosophy recognises the goal of attempting to define a consistent ‘reality’ about what might be happening in a particular area of study, whilst accepting that the pursuit of this reality will always be influenced by individual frames of meaning, embedded within a dynamic, socio-cultural context. As such, it was felt to accommodate the integration of both the qualitative elements of this research, and the use of structured questionnaires based on ‘pre-established’ theoretical constructs.

Management of pre-existing knowledge

Within the context of grounded-theory, the hindrance of prior knowledge and assumptions held by the researcher to the development of a truly inductive analysis remains debated (Walls, Parahoo & Fleming, 2010). However, there is a growing pragmatic acceptance that researchers’ involvement in research is rarely approached from a naïve standpoint, and true suspension of knowledge is unrealistic (Charmaz, 2006). Given the pre-selection of questionnaires prior to commencing the grounded-theory element of the study, the researcher was aware of having made assumptions regarding the possible constructs which may be relevant to help-seeking and psychosis. Furthermore, the researcher had also completed an initial brief literature search on help-seeking in mental health, in order to meet the requirements of institutional and ethical bodies. A number of measures were therefore put in place to

limit any further additional influence on the data analysis. This included postponing a detailed secondary literature search until after the qualitative data had been collected and analysed. Questionnaires were also given to participants on a second, separate occasion from the interview, to try and reduce cross-contamination of concepts. The questionnaires were not reviewed or scored by the researcher until after the qualitative analysis had been completed. The use of memos and supervision were continually integrated into the research process, to attempt to make any influences more transparent and encourage reflexivity (Carolan, 2003).

Procedure

Ethical approval was received for both the qualitative and questionnaire based elements of this study (West of Scotland Regional Ethics committee 01; 12/WS/0144). More detailed information regarding procedure and participant profile is provided elsewhere and will not be replicated in depth here².

A summary of the recruitment flow is shown in Figure 1. In total, nine participants took part in the study.

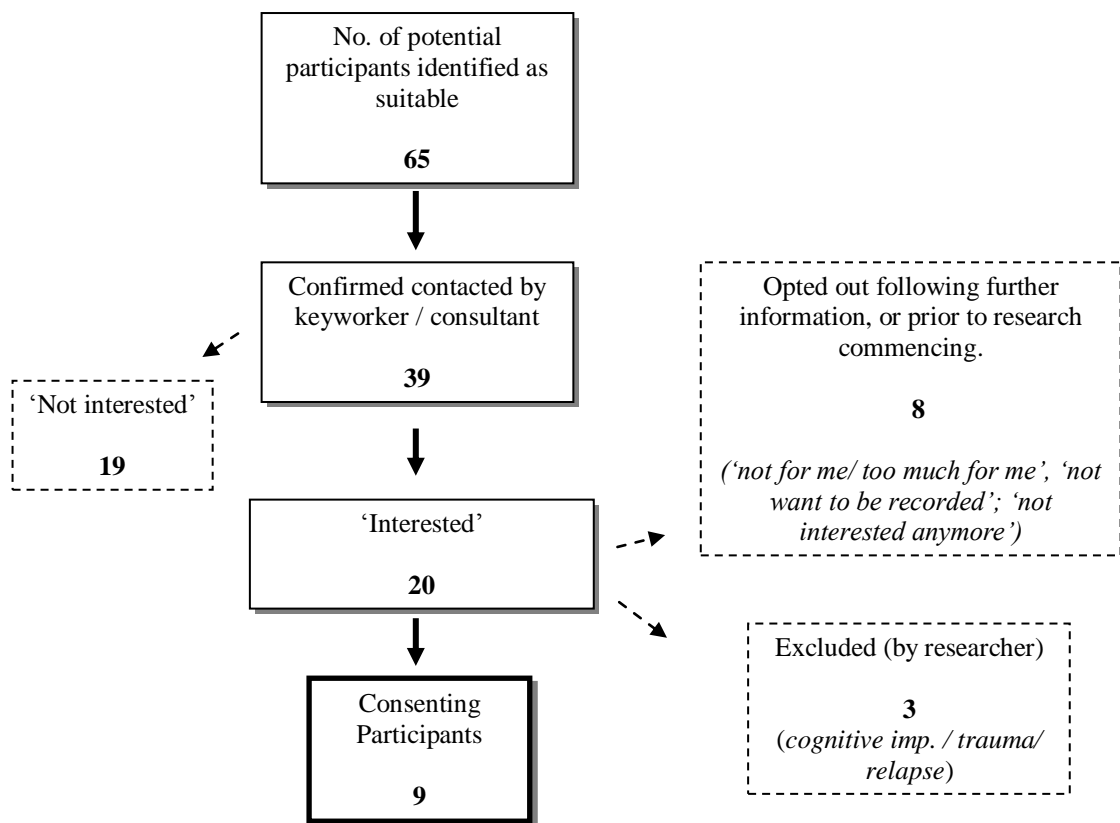
Following the interview component of the research, a separate session was arranged a minimum of a week later for questionnaire completion. Participants were given the choice of self-completing the questionnaires or having support from the researcher. All participants chose to have the researcher's support with questionnaire completion.

Participants

All participants were adult service users from long-term rehabilitation services, aged between 30 and 70 years old (mean 50.4 years), and had been diagnosed with a schizophrenia-related disorder. Three participants were inpatients (Suzie P03, Matthew P08, and Hamish P09), although all individuals had an extensive history of hospital admissions (range 4 [*long term*] – 26 admissions). The remaining participants were in mental health specialist supported accommodation.

² Supporting additional information regarding procedure and participant characteristics are given in the preceding article and thesis appendices.

Figure 1. Summary of recruitment flow.



Selection of Measures

Measures for the quantitative component of the study were selected based on their perceived relevance to factors related to help-seeking and service attachment in psychosis, as well as their face validity, speed and ease of completion. The measures were completed and scored in line with the publisher's guidelines.

Attachment:

- i) *The Relationship Questionnaire* (RQ; Bartholomew & Horowitz, 1991): This brief self-report measure of adult attachment in close relationships offers a categorical and dimensional way of classifying individual attachment style. Respondents choose from four, forced-choice paragraphs describing prototypical attachment patterns in adult relationships, followed by a 7-point Likert scale, rating their degree of correspondence to each prototype. Moderate stability of

self-classification has been found for this measure (Scharfe & Bartholomew, 1994).

- ii) *Service Attachment Questionnaire (SAQ*: Goodwin *et al.*, 2003). The SAQ is a 25 item rating scale which measures the degree to which mental health services meet a client's attachment needs. It was designed for use in both inpatient and community mental health settings and shows good internal reliability.

Recovery Style.

- i) *Recovery Style Questionnaire (RSQ*; Drayton *et al.*, 1998). The RSQ is a 39-item self report measure designed to investigate an individual's recovery style in psychosis. Questions are grouped into 13 subscales and each subscale is given a score of 1 (integration-type) or 0 (sealing-over type). Scores are mapped onto a 6-point global scale representing the degree of integration shown by each participant. Low global scores reflect a greater tendency towards 'integration' recovery style. The scale has been shown to have strong psychometric properties within a clinical setting (Drayton *et al.*, 1998).

Appraisal of illness:

- i) *The Personal Beliefs about Illness Questionnaire – Revised (PBIQ-R*; Birchwood *et al.*, 2012). The PBIQ-R is made up of five subscales i.e. loss, entrapment, control, social marginalisation and shame, relating to an individual's experience of their psychosis. Participants rate their strength of agreement to 29 statements on a four-point scale (strongly disagree to strongly agree). The subscales have shown themselves to have good internal consistency and validity and reasonable reliability in a population with psychosis.

Comparing the data

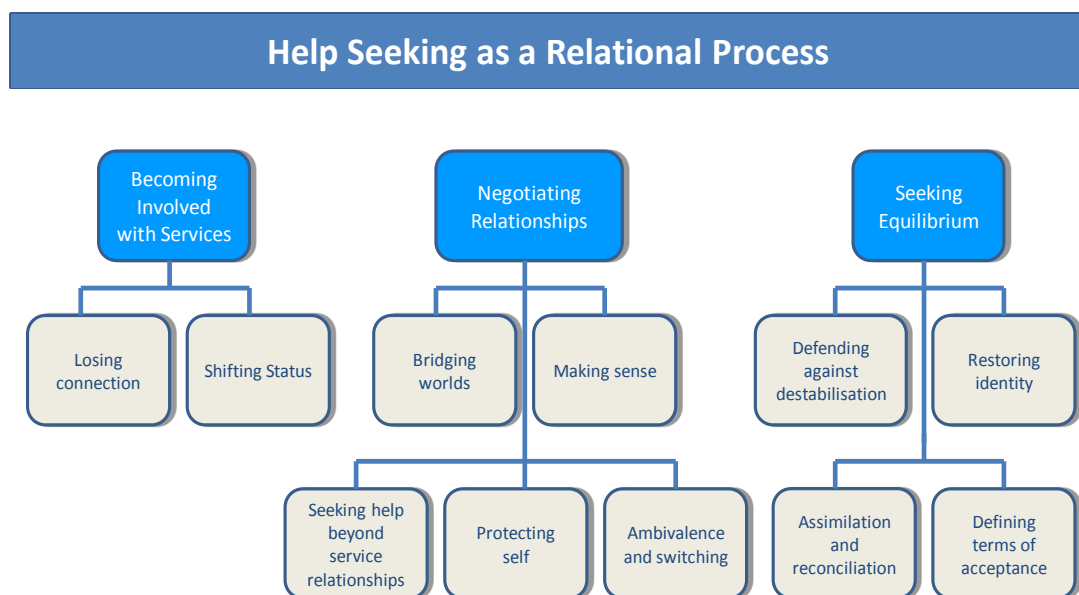
Categories generated from the interview data were cross-referenced with the data from the quantitative measures and contextual participant information gathered from medical records. Particular attention was paid to any instances of apparent cohesion or contradiction between data.

Results

Qualitative Results

A full summary of the qualitative results from the grounded theory analysis is provided in a separate article. However, for ease of reference an overview of the categories generated from the grounded theory analysis is given in Figure 2.

Fig 2: Summary of the process categories emerging from the grounded-theory analysis



Questionnaire Outcomes

A summary of scores obtained on the questionnaires, along with the main qualitative categories associated with their narratives is given in Table 1.

Relationship Questionnaire (RQ)

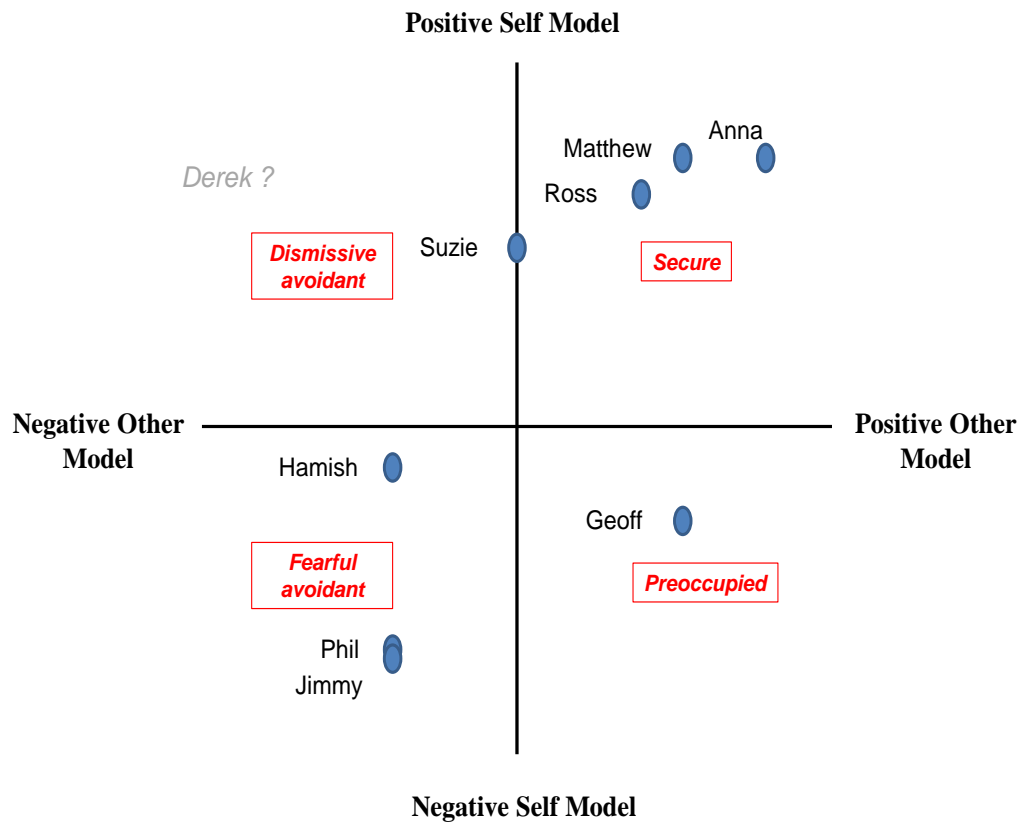
Of the nine participants included in this study, eight responded to the RQ. Five participants classified themselves as having predominant, insecure style attachment organisation in close relationships, four of which were avoidant (Suzie P03; Hamish, P09; Phil P01 and Jimmy, P07) and one preoccupied type (Geoff, P02). Three participants (Ross, P05; Anna, P06 and Matthew, P08) self-reported a predominant, secure style of relating. One individual (Derek, P04), chose not to complete the questionnaire as he stated he did not have close relationships. It could be very tentatively hypothesised by the researcher, that a number of elements within Derek's (P04) account were consistent with avoidant dismissive style of attachment, including his preference for self-sufficiency and rejection of the significance of relationships with others. It should be noted that with the exception of Anna (P06) and Matthew (P08), correspondence to prototypes was not solely weighted to the one attachment style.

A two dimensional representation of participants self-reported attachment styles based on model of self and other derived from scores on the RQ is provided in Figure 3.

Table 1: Summary of questionnaire scores for participants.

	Dominant Attachment Prototype (RQ)	RSQ	SAQ (out of 100)	PBIQ	Key category contribution (top 3)
Phil (P01)	Fearful	Tends towards integration	72	Control (11/30) Shame (16/36) Entrapment (17/36) Loss (17/43) Soc. Marg. (13/30)	Assimilation and reconciliation Losing connection Making sense
Geoff (P02)	Preoccupied	-	60	-	Changing status Protecting self Seeking help beyond service relationships
Suzie (P03)	Dismissing	Mixed picture – sealing over predominates	62	Control (11/30) Shame (17/36) Entrapment (14/36) Loss (18/43) Soc. Marg. (11/30)	Protecting self Making sense Seeking help beyond service relationships
Derek (P04)	<i>(Dismissing?)</i>	<i>(Sealing over)</i>	-	-	Seeking help beyond service relationships Bridging worlds Ambivalence and Switching
Ross (P05)	Secure	Integration	80	Control (14/30) Shame (15/36) Entrapment (17/36) Loss (14/43) Soc. Marg. (11/30)	Bridging Worlds Defending Against Destabilisation Making sense
Anna (P06)	Secure	Tends towards integration	88	Control (12/30) Shame (8/36) Entrapment (14/36) Loss (19/43) Soc. Marg. (6/30)	Losing connection Bridging worlds Defending against destabilisation
Jimmy (P07)	Fearful	Mixed picture integration dominates	62	Control (15/30) Shame (13/36) Entrapment (18/36) Loss (14/43) Soc. Marg. (14/30)	Defining terms of acceptance Making sense Protecting self
Matthew (P08)	Secure	Integration	78	Control (15/30) Shame (16/36) Entrapment (19/36) Loss (19/43) Soc. Marg. (12/30)	Assimilation and reconciliation Restoring individuality Protecting self
Hamish (P09)	Dismissing	Tends towards integration	53	Control (17/30) Shame (16/36) Entrapment (21/36) Loss (23/43) Soc. Marg. (16/30)	Bridging worlds Seeking help beyond service relationships Losing connection

Figure 3. Self-rated attachment styles based on model of self and other.

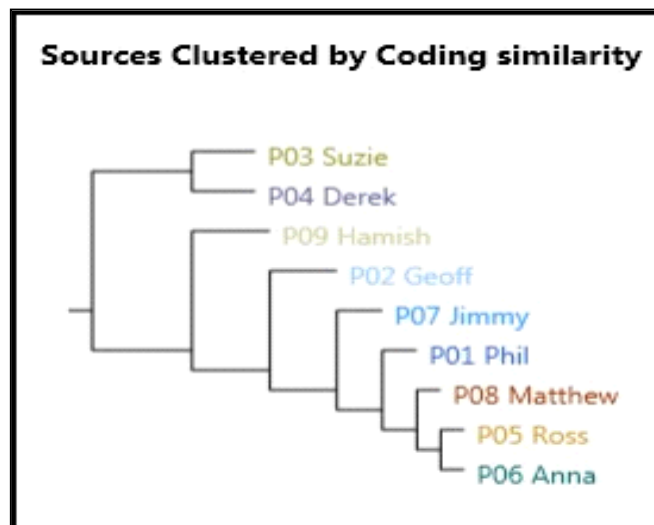


NB: Calculation of scores: ‘Model of Self’ = (Secure + Dismissing) - (Fearful + Preoccupied); ‘Model of Other’ = (Secure + Preoccupied) – (Dismissing + Fearful).

Clustering comparison

Whilst recognising the limitations in relation to ‘small n’ qualitative studies, the use of NVivo 10 clustering analysis, based on coding similarity between participants (Figure 4), showed that the narratives of participants who self-reported a dominant secure style of attachment were most alike. Those most dissimilar from these accounts were Suzie (P03) and Derek (P04), who were both associated with more dismissing avoidant styles of attachment.

Fig 4. Clustering of participants based on coding similarity (Jaccard coefficient)



Service Attachment Questionnaire (SAQ)

The mean score for attachment to services amongst the sample was 69.5 (SD=12). This was below the mean reported in comparative clinical psychosis studies amongst inpatients and community patients, suggesting a lower degree of service attachment in the current study (Blackburn *et al.*, 2010; Goodwin *et al.*, 2003). However, as with the comparison studies, community patients reported higher levels of service attachment than inpatients. It is interesting to note that Matthew (P08) rated his levels of service attachment significantly higher than the other inpatients in the study, and was also the only inpatient with a secure type attachment affinity.

Recovery Style Questionnaire (RSQ)

Mean global score for the participant group (n=7) was 2.1 (SD=1.1). This was below the mean reported amongst a community population of individuals with schizophrenia (Drayton *et al.*, 1998, mean age = 31yrs), indicating that participants in the current study tended more towards integration. However, small numbers of participants, questionnaire non-completion and demographic differences in the current study, limit accuracy of comparison. Given the small number of sealing over respondents in this study, a further comparison was carried out on the integration style only group, which showed that the degree of integration demonstrated by

participants in the current study was in line with that reported in the comparison group.

Of the eight participants who attempted to complete the RSQ, six reported a stronger tendency towards an integration style of recovery. Suzie (P03) reported a stronger tendency towards ‘sealing over’, and one further participant, Derek (P04,) felt unable to respond to enough items on the questionnaire to allow an overall recovery style to be assessed. However, of the nineteen questions answered, fourteen were indicative of a ‘sealing over’ recovery style.

Personal Beliefs about Illness Questionnaire-Revised(PBIQ-R)

This chronic psychosis group reported a particularly high sense of entrapment and loss as a result of their illness. This was more prominent for the inpatients in the study. In comparison to a first episode psychosis sample (Birchwood *et al.*, 2012), the average subscale scores for all participants were significantly higher in the current study, showing higher negative beliefs about the consequences of illness held amongst the more chronic population in this study.

Discussion

Integration of Grounded Theory and Questionnaire Outcomes

Based on the additional participant characterisation acquired from the data gathered in the questionnaires, a number of points for reflection arise in context of the qualitative data analysis.

Grounded theory of help-seeking and the significance of relating

The grounded theory emerging from the qualitative component of the study emphasises the significance of the capacity to form relationships for the development of a positive and effective help-seeking orientation within services. It may therefore be anticipated that participants reporting a more secure attachment style, linked to a positive sense of self and other, may be more likely to demonstrate higher levels of

service attachment, and offer a more adaptive account of help-seeking within their accounts.

There is some evidence to support this hypothesis from a comparison of the grounded theory analysis with the RQ and SAQ outcomes. Firstly, the three participants in the study self-reporting a predominantly secure style of attachment also scored highest on the SAQ, suggesting a greater propensity for a service relationship to be formed. The two community patients who had a more secure style of attachment (Ross, P05 and Anna, P06), offered positive accounts of inpatient admissions and collaborative approaches to help-seeking within their narratives, with past admissions being voluntary. The third participant with a secure-style attachment (Matthew, P08) was an inpatient, who described a more resistant approach to his initial admission following late-onset psychosis. However, he did report a relatively strong level of service attachment, and was the only inpatient in the analysis who had been able to make a more positive transition within the service towards voluntary admissions. His account also demonstrated some evidence of a positive sense of self within the service, as well as effective relationships with staff. The only other individual who viewed hospital admission positively and had a history of voluntary admission, was Geoff (P02), who self-reported a predominant preoccupied style of relating (positive sense of other). The quantitative results therefore offer some support for the hypothesis that an individual's sense of other may play an important role in promoting service acceptance and help-seeking at times of relapse, as highlighted in the proposed grounded theory model.

It is also of interest to note that participants who self-reported more avoidant styles of insecure attachment (Hamish P09, Jimmy P07, Phil P01, Suzie, P03 and Derek P04), expressed significant difficulties in being able to feel their inner experience was truly understood and responded to appropriately by service staff, particularly during times of hospital admission. Those associated with higher levels of dismissive-avoidant patterns of attachment (Suzie, P03, Hamish, P09 and Derek, P04), appeared to cope with this by emphasising self-sufficiency or turning to sources of help beyond staff relationships. Again, this offers some links between the constructs

of attachment and help-seeking. Recent interest in the attachment literature has been shown towards the links between insecure attachment and impaired mentalisation capacity (e.g. Liotti & Gumley; 2008; MacBeth *et al.*, 2011). Gumley and Schwannauer (2006) hypothesise that impaired affect regulation and mentalisation may be associated with deactivating strategies, which in turn may relate to sealing over styles of recovery and poor service engagement. It has also been proposed that low reflective functioning may initially serve a protective function for some, protecting individuals from the destabilising effect of potential negative affect, but eventually impeding progress in recovery (Braehler & Schwannauer, 2011). Within the model proposed in this study, it could be hypothesised that poor capacity for individuals to reflect on their own mental states and infer those of others within a service context could act as a barrier to the formation of a shared framework of understanding between service user and professionals, thus impairing engagement. Furthermore, in relation to the ‘self’ and ‘service experience’ dynamic in the model, it could hinder the reconciliation and understanding of service experiences, activating greater levels of negative affect and causing long term rupture across all service relationships. This requires further investigation and validation.

Finally, it was noted that higher scoring participants on the SAQ made a key contribution to categories falling within the ‘*seeking equilibrium*’ stage of the qualitative analysis, describing greater attempts to reach a place of acceptance and stability in relating to services. Again, this reinforces the importance of help-seeking as a relational construct, negotiated within a context of positive or negative relationships with services.

An apparent exception to some of this discussion is found with Phil (P01), who self-reported a prevalent fearful-avoidant style of attachment, yet expressed a relatively strong level of service attachment. He also made a significant, positive contribution to categories within the ‘seeking equilibrium’ stage of analysis, demonstrating some indications of being able to reconcile painful past conflicts, as shown in the quote below.

"I also ...sort of have the point of view looking back... I can understand my mum and dad's point of view because they were, in the process of moving house and I think it was just very difficult to erm.... just the whole time was kind of very up in the air and they weren't, they didn't have a base to kind of work from for themselves. Erm, and they had a lot of things, a lot of things on their mind, as I say". (Phil, P01).

This discrepancy may be the result of limitations in attachment assessment tools, where Phil (P01)'s interpretation of close relationship may be specific to romantic interactions, which does not reliably generalise to his attachment style in other contexts. Indeed, within his account he refers to close reciprocal, loving bonds with his family and a sense of sanctuary at his family home, which could be more consistent with secure type traits. Alternatively, it is recognised that the construct of service-attachment may be likely to tap into something more directly relevant to, and indicative of, help-seeking orientation within services, than measures of adult attachment alone. Indeed, there are some initial findings in the literature that show that whilst attachment style is correlated between keyworker and close relationships, the level of anxiety and avoidance shown within relationships may vary (Berry *et al.*, 2007), with lower levels of insecure attachment being shown in keyworker versus other attachment relationships (Arbuckle *et al.*, 2012).

The role of internal beliefs about illness and help-seeking

The grounded theory model of help-seeking also predicts that individual's attitudes and beliefs towards their psychosis may impact upon the way they interpret and respond to service experiences, as well as influencing their capacity to link into common explanatory frameworks within services. For example, it may be tentatively predicted that participants scoring more highly on an integration style of recovery on the RSQ, may have made a higher contribution to categories falling within the '*seeking equilibrium*' stage of analysis, which is associated with a move towards contextualising their need for help within services. This did indeed appear to be consistent with the data, with the exception of '*defining terms of acceptance*' category. However, on further review of the nature of contributions to this latter category, participants appeared to be split in relation to the way in which they approach acceptance of the role of services which was more reflective of their

capacity for integration. For example, Derek (P04) and Jimmy (P07), who demonstrated fewer signs of integration than a number of the other participants, took a more controlling and defensive stance in how they framed and responded to service intervention, for example with both downplaying the mental health component of their support.

Suzie (P03) was the only participant completing the RSQ who reported a ‘sealing over’ recovery style. Within her account she expressed a great difficulty in initiating help-seeking due to the perceived threat of being viewed as vulnerable and being retained in her current inpatient environment. Furthermore, she struggled to make sense of why others perceived her to be unwell. This again supports a potentially relevant link between recovery style and orientation to help-seeking. Suzie’s high reported sense of control and low reported sense of entrapment on the PBIQ-R is also of interest, reinforcing the idea that a sealing over approach may play a protective role in reducing distress for some (Tait *et al.*, 2004), albeit it may hinder connection with service staff and consequently help-seeking capacity.

It is notable that overall, the researcher was able to make fewer direct connections between participants responses on the PBIQ-R and the grounded theory analysis. This was potentially unexpected given the perceived overlap between social-rank theory underpinning this measure (Birchwood *et al.*, 2012) and the themes of relative sense of self, power and status emerging from the grounded theory analysis. It is suggested that this may be a factor of the PBIQ-R being developed within first-episode populations, and more indicative of initial responses to help-seeking and service engagement, rather than a longer term capacity to adjust and overcome these experiences to allow future engagement. Thus, for example, Phil (P01) and Suzie (P03) both expressed a strong sense of shame on their PBIQ-R, and also describe initial hostility and withdrawal from others. However, their help-seeking orientations remained significantly different, and more represented by their measures of recovery style. It is also possible that the significance of the PBIQ-R in relation to help-seeking lies in the way in which experiences of loss of social status interact with an individual’s sense of self and other, which is not directly accounted for by this

measure. As such, someone such as Hamish (P09) who has relatively high scores across most of the PBIQ-R subscales and a more negative view of self and other, may find fewer ways to accept, resolve or cope with these beliefs than someone such as Matthew (P08), whose more positive sense of self and other may provide him with more options for compensating for his losses, improving his sense of status and reducing his sense of marginalisation (e.g. becoming a caregiver on the ward).

It is worth noting that a study by (Kvrgic *et al.*, 2012) looking at attachment style and quality of therapeutic alliance in individuals with psychosis, found that a better prediction of therapeutic alliance could be made when considering an individual's recovery orientation, self esteem (as related to self stigma) and insight as variables alongside avoidant attachment style. They also identified that positive symptoms of psychosis could have a detrimental impact on therapeutic alliance if promoting an increased sense of negative self-stigma. Whilst not solely focusing on therapeutic alliance, the findings of the current study could be viewed as highly compatible with these findings, also emphasising the importance of view of self, recovery style and symptoms *within the context of* their impact on relative sense of self as influences in a person's capacity to engage with others.

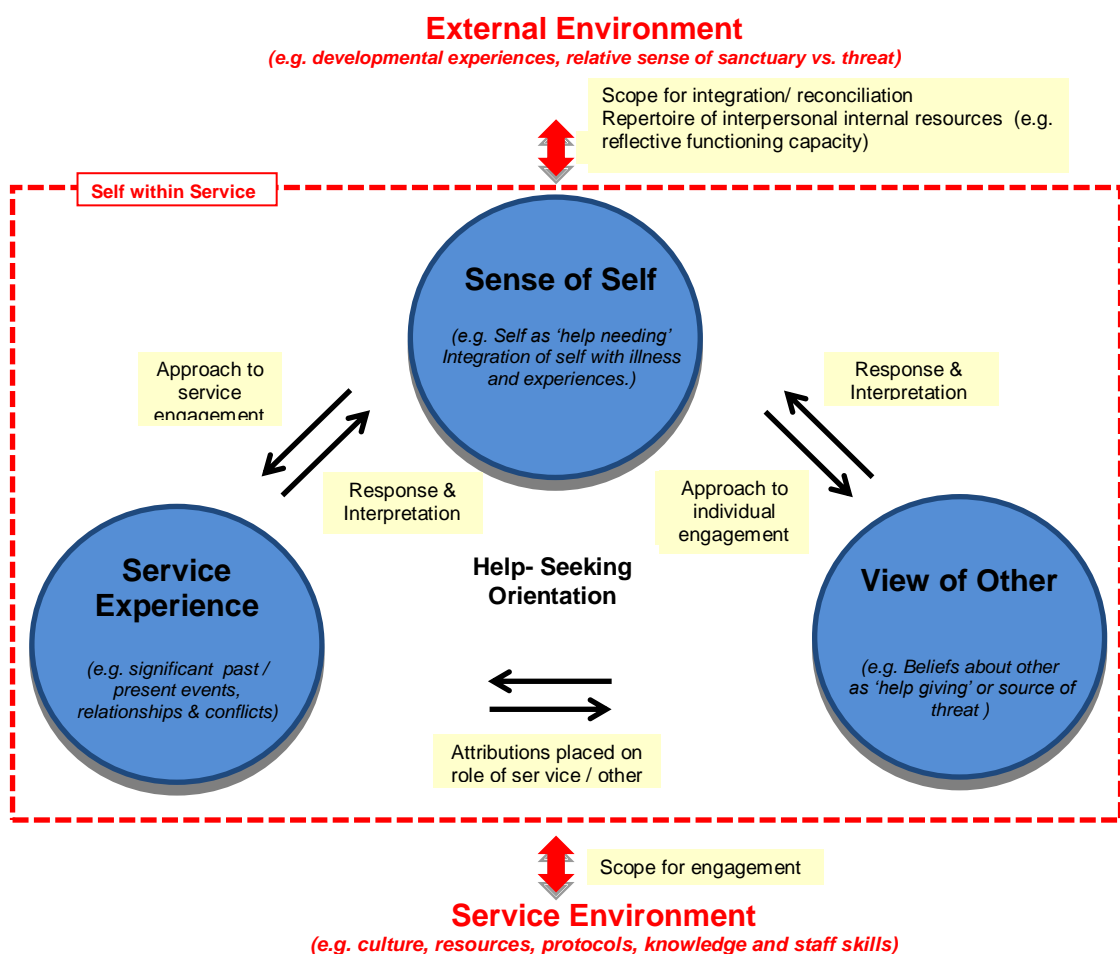
Development of the Grounded Theory Model

Based on the additional comparison of findings, two refinements to the grounded theory model are proposed (see Figure 5).

Firstly, within the 'self' domain, the way in which beliefs about illness are integrated into an individual's sense of self are emphasised (as captured by 'recovery style' construct), rather than beliefs about illness *per-se*. Therefore, an individual's orientation to help-seeking is more likely to be affected if the meaning an individual attributes to their psychosis also significantly detracts from how they see themselves relative to others.

Secondly, in the interface between external environment and self within service, the possible role of resources stemming from early development experiences and relationships outside of services (*e.g.* reflective functioning capacity) is specifically acknowledged. This again highlights that there may be protective factors stemming from developmental experiences which can facilitate help-seeking, even in the face of difficult service experiences and personal distress.

Figure 5: Refined grounded theory model of help-seeking in mental health services for individuals with chronic psychosis.



Limitations and Recommendations

A number of limitations to the second part of this study are acknowledged. Firstly, it is recognised that the small scale nature of this study only allows for observational,

qualitative analysis of measures and comparison with the emerging grounded theory. It is also recognised the heading of ‘chronic psychosis’ may mask significant heterogeneity within this population, and that the study is based on a ‘snapshot’ of experience at one point in time. As such, larger scale longitudinal exploration of the issue of help-seeking may help to bridge the current gaps in the literature, offering services insight into possible opportunities for understanding and intervention across individual recovery journeys.

Secondly, it is acknowledged that use of the Relationship Questionnaire was chosen due to its brevity and capacity to be used as both a continuous and categorical measure for classifying attachment style (Bartholomew & Horowitz, 1991). However, it is recognised that the validity and reliability of this tool is not clearly established within this clinical population, and as with other self-report tools, may only capture an individual’s idealised or easily accessible representation of an individual’s attachment style (Shaver & Mikulincer, 2004.). Individual interpretation of what a ‘close relationship’ meant may have varied, and current service circumstances and opportunity for social relationships may have influenced the reliability of responses given to the attachment measure. It was also noted that a number of participants found the questionnaire completion element of this study challenging, with some opting out completely. As well as missing data, it is possible that the accuracy of some people’s responses may have been affected by motivation levels and expectation effects. Indeed, there is some evidence to suggest that participants with more avoidant styles of coping may find accurate self-reporting of inner states difficult (Dozier & Lee, 1995), as such, responses to questionnaires amongst these individuals may not accurately represent inner states.

For future studies, it may be useful to include a measure of reflective functioning, to offer a useful addition to the exploration of help-seeking and service engagement. As well as providing a framework within which to explore differences and possible limitations in narratives between participants, it may be useful to expand on the discussions initiated in this chapter, regarding the role it may play in the relational processes of help-giving and receiving in this population.

Additional Clinical Implications

The adapted grounded-theory model suggests that an awareness of an individual's attachment style, level of service attachment and recovery style may provide clinicians with additional tools to understand an individual's help-seeking orientation and opportunities for engagement. It has been argued that during the course of recovery from psychosis, services may benefit from taking into account coping styles and attempt to work within these, rather than attempt to override or cajole an individual into adopting an alternative stance (McGlashan, 1987; Tait *et al.*, 2004). This argument could be extended to encompass service response to help-seeking orientations. For example where individuals who appear to adopt a sealing-over style of recovery and find help-seeking challenging, the initial emphasis may be on providing a more informal, normalising programme of support, where emphasis may be placed on voluntary access to peer support workers or activities which rely less on illness-specific professional engagement and offer opportunities for re-establishing a stronger sense of identity. This could be a dynamic process, where new opportunities for different styles of engagement open up as service attachment increases, or interpretation of service experiences change for an individual.

Conclusions

Whilst the limitations of the small scale study are recognised, the comparison of an emergent grounded theory model of help-seeking with additional participant characteristics has opened up a number of additional areas for discussion, including the relevance of individual attachment, service attachment and recovery style to help-seeking orientation in chronic psychosis. However, the specific pathways by which these factors may mediate or influence help-seeking require further definition and exploration. This may offer clarification on the way in which services can best support and engage with individuals, in the hope of developing an optimum approach for help-giving and help-acceptance with the aim of reducing revolving admissions and recurring relapse.

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Appendix A: Quality Checklist for Appraisal of Included Studies.

	Internal / External Validity – Potential Contributing Factors³
Study Focus	1. Were the aims of the research clearly stated along with any relevant, pre-specified hypotheses ?
	2. Did the author establish a clear justification for the research within the existing evidence base ?
Recruitment	3. Did the author provide a clear outline of the recruitment process ?
	4. Was the recruitment setting clearly stated (e.g. inpatient / outpatient) ?
	5. Was the recruitment eligibility / exclusion criteria clearly stated ?
	6. Was the initial recruitment response rate reported ? If yes a) Were the characteristics of study refusers / drop outs specified ? b) Were any differences between these and the sample used highlighted ?
	7. Was the sample <i>representative</i> (i.e. specifically selected to represent a spectrum of its target population <i>e.g.</i> psychosis - representative demographics, duration and severity of illness) ? NB: vs. <i>convenience</i> sample (e.g. all willing to participate from an available pool – geographical or service, or those taking part in another study).
Sample Characteristics	8. Were the following demographic characteristics of the sample described adequately ? a) Age b) Gender c) Education level d) Ethnicity e) Relationship Status f) Accommodation
	9. Were the following clinical characteristics of the sample described adequately ? a) Diagnosis b) Diagnostic method specified (e.g. DSM-IV/ ICD-10) c) Duration of illness d) Current treatment (medication / psychotherapy etc.) e) No. of inpatient admissions f) Current symptom severity
	10. Was the sample ‘homogeneous’ (in relation to psychosis-related diagnosis or presence of psychotic symptoms) ?
	11. Was the sample size based on described and adequate power calculations ?
Sample Size	12. Was an established, standardised measure of attachment used ?
Procedure: I. Measuring Attachment	13. Were the psychometric properties of the tool acknowledged (e.g. reliability and validity) ?
	14. Was it confirmed that the tool was validated with a comparable population ? If yes, with a:

³ Response Ranges: Yes / No/ Partially / Not applicable.

	Internal / External Validity – Potential Contributing Factors³
	<ul style="list-style-type: none"> i) General clinical population ii) Clinical / diagnostically equivalent population but not in same clinical setting as study (e.g. inpatients with psychosis for a community psychosis study). iii) Equivalent population and in same clinical setting as study
	<ul style="list-style-type: none"> 15. a) Did the author provide adequate details on measure completion ? b) Was it stated that adherence to the assessment procedure was monitored ? c) Was the competence/ training of those delivering measures verified ?
	16. Was it made clear which attachment relationship domain was being investigated by the tool ?
	17. Did the author consider issues arising from the comparison of attachment across different relationship domains (e.g. parent-child, staff, romantic, general) ?
	18. a) Were other measures used ? <i>If yes:</i>
Procedure: II. Measurement of non-attachment variables	<ul style="list-style-type: none"> b) Were these measures <ul style="list-style-type: none"> i. all non-standardised ii. mix of standardised and non-standardised iii. all standardised c) Was the reliability and validity of each measure provided ? d) Was it clear whether the standardised measures were valid for use for individuals with psychosis ? <i>If yes</i> was this: <ul style="list-style-type: none"> i. some of them ii. all of them
	19. Where relevant, did the author consider any confounding effects of multiple measures ?
	20. Were the completion procedures described clearly and in enough detail to be replicable ?
Results	21. Did the analysis seem appropriate to the study design and type of measures used ?
	<ul style="list-style-type: none"> 22. a) Was it clear whether the analysis included all participants ? b) Were the reasons for any drop out adequately described ?
	23. Were the results reported clearly (in line with any hypotheses where relevant) ?
	24. Were descriptive statistics adequately reported for outcome measures (e.g. mean, median, confidence intervals etc.) ?
Discussion	25. Did the conclusions drawn from the study appear to fit with the data ?
	26. Did the author adequately recognise and address any limitations of their methodology ?
	27. Were the results and conclusions placed in context with the existing evidence base ?
	28. Were the clinical implications specified ?
Generalisability/ External validity	29. Could the results be confidently applied to the local population (differences between local/ study population – cultural, geographical, ethical) ?

Appendix B: Authors submission guidelines for ‘Clinical Psychology Review’.

Article structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered. Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices.

In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prisma-statement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication.

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See <http://www.elsevier.com/highlights> for examples.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Table footnotes

Indicate each footnote in a table with a superscript lowercase letter.

Electronic artwork

General points

- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.
- Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Size the illustrations close to the desired dimensions of the printed version.
- Submit each illustration as a separate file.

Figure captions

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from <http://books.apa.org/books.cfm?id=4200067> or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at <http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html>

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. **References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).**

Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59.

Reference to a book: Strunk, W., Jr., & White, E. B. (1979). *The elements of style*. (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

Appendix C: Copy of ethical and R&D approval correspondence

University Hospitals Division

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

DN/AC/approval

21/06/2012

Ms Chrissie Johnson
NHS Lothian
Psychology Department, 2nd Floor McKinnon
House
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh

Dear Ms Johnson



Lothian

Research & Development
Room E1.12
Tel: 0131 242 3330
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R&DOffice@luht.scot.nhs.uk

Director:

Professor David E Newby

Lothian R&D Project No: **2012/P/PSY/16**

Title of Research: Experiences of help seeking amongst individuals with multiple episode psychosis: A mixed methods exploration.

REC No: 12/WS/0144

CTA No: N/A

Eudract: N/A

PIS: Version 2 dated 12 June 2012

Consent: Version 1 dated 23 May 2012

Protocol No: V1 (23/05/2012)

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

Following a Research Ethics Committee final favourable opinion, final copies of all project documentation (with revised version numbers) should be sent, with the Research Ethics Committee letter of favourable opinion, to the R&D office. Management approval will only be valid after favourable opinion has been received.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

Prof David Newby
R&D Director

Cc Paul Dearie, QA Manager

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde
West of Scotland REC 1
West of Scotland Research Ethics Service
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18 June 2012

Ms Chrissie Johnson
Trainee Clinical Psychologist,
NHS Lothian
Department of Psychology,
Royal Edinburgh Hospital, 2nd Floor Mackinnon House
1 Morningside Terrace, Edinburgh
EH10 5HF

Dear Ms Johnson

Study title: Experiences of help seeking amongst individuals with multiple episode psychosis: A mixed methods exploration.
REC reference: 12/WS/0144

The Research Ethics Committee reviewed the above application at the meeting held on 12 June 2012. Thank you for attending to discuss the study.

Ethical opinion

The committee had several questions for you which were answered to their satisfaction.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to

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the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

The committee require the undernoted minor amendments to the Patient Information Sheet and Consent Form:

Information Sheet:

- a) The font size should be amended to be slightly larger -standard NHS font size.
- b) Page 1 - 5th paragraph - delete as this is repeated further down more appropriately.
- c) Page 2 - Para in respect of digital recorded - add sentence indicating how the recording will be destroyed and when.
- d) Page 3 - Who has reviewed the study - This should read West of Scotland REC (1) has reviewed the study.

Consent Form:

- a) Delete section 8.

GP Letter

- a) 2nd para 2nd line - delete "blank"

The above amended documentation should come back to the Administrator for checking and filing.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
----------	---------	------

Covering Letter		23 May 2012
GP/Consultant Information Sheets	1.0	23 May 2012
Interview Schedules/Topic Guides	1.0	23 May 2012
Investigator CV	Ms Chrissie Johnson	23 May 2012
Other: CVAc2	1.0	23 May 2012
Other: Cover Questionnaires	1.0	23 May 2012
Other: Supervisor CV		02 April 2012
Participant Consent Form	1.0	23 May 2012
Participant Information Sheet	1.0	23 May 2012
Protocol	1.0	23 May 2012
Questionnaire: PBIQ		
Questionnaire: RSQ		
Questionnaire: RQ		
Questionnaire: SAQ		
REC application		23 May 2012
Referees or other scientific critique report	University Comments	12 April 2012

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.


Further information is available at National Research Ethics Service website > After Review

12/WS/0144

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely


Dr John Hunter
Chair

Email: andrea.torrie@ggc.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers" SL-AR2

Copy to: *Ms Marianne Laird*

Ms Karen Maitland, The Queen's Medical Research Institute

West of Scotland REC 1
Ground Floor, Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT

Ms Chrissie Johnson
Department of Psychology,
Royal Edinburgh Hospital,
2nd Floor Mackinnon House
1 Morningside Terrace,
Edinburgh
EH10 5HF

Date 28th June 2012
Direct line 0141-211-6238
Fax 0141-211-1847
Ref AHT/SAJ

Dear Ms Johnson

Full title of study: Experiences of help seeking amongst individuals with multiple episode psychosis: A mixed methods exploration.
REC reference number: 12/WS/0144

Thank you for your letter of 26th June 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 12 June 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		26 June 2012
Other: Professionals information Sheet	version 2	25 June 2012
Participant Consent Form	version 2	25 June 2012
Participant Information Sheet	version 2	25 June 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/WS/0144

Please quote this number on all correspondence

Yours sincerely

Andrea Torrie, Senior Lead Administrator
E-mail: andrea.torrie@ggc.scot.nhs.uk

Copy to: Ms Marianne Laird,
Ms Karen Maitland, The Queen's Medical Research Institute

Appendix D: Excerpt from research memo ‘The Personal Meaning of Help Seeking’

Memo (The Personal Meaning of Help-seeking)

... participants’ responses to what were perceived as even direct question about help-seeking appearing tangential. However, as the process repeated itself I realised that I was also approaching this topic with expectations heavily influenced from a professional /service perspective. As such, I had a preconceived idea of how help-seeking was defined (i.e. initiating a request for help from others), and was at risk of overlooking how help-seeking through participants’ eyes was embedded in much greater, complex system of meaning about the ‘self’ and ‘other’ than previously anticipated.

This even spilled over into our own interview interactions, such as Suzie (P04) warning me ‘not to tell’ when describing an unhelpful experience with a professional. It is also summarised in Hamish’s (P09) multifaceted description of the factors which made a help-receiving experience from a staff nurse memorable and significant, extending way beyond a simple model of knowledge transfer or a ‘listening ear’.

*“It was a different sort of fatherhood, something that really did erm... perhaps a wee bit romantic ...I don’tperhaps because it ended bitterly it ended without any feeling or without any point. So I think that it is very sad now that erm that I haven’t been able to contact him”. **Hamish, P09.***



Help seeking and psychosis: an exploration.



Participant Information Sheet

I would like to invite you to take part in my research study. Before you decide, I would like you to understand why the research is being done and what it would involve for you. The following information describes the research in more detail. Talk to others about the study if you wish. I would also be glad to talk to you if you have any further questions, or if there is anything that is not clear.

What is the purpose of the study ?

This study is being carried out as part of an educational project for submission as part of the University of Edinburgh Doctorate in Clinical Psychology programme.

I am interested in talking to people who have coped with more than one episode of psychosis. I am particularly interested in learning about how people feel about seeking help from others, and from services. I am also wanting to hear about people's past experiences of seeking help, good or bad, and if they feel these experiences have changed their attitudes to seeking and receiving support.

I believe that getting a better understanding of individual experiences of help seeking, will allow services to appreciate the range of previous experiences that people may have encountered when coming to services, and may help us to develop ways to better support people with similar experiences in future.

Why were you invited to participate ?

I have asked a range of healthcare professionals to pass on information about this study and tell people how they can participate. They are giving this information to people that they work with, who have had multiple experiences of psychosis and who they feel may be able to tell us about their experiences and contribute to this research.

You were invited to participate because they have identified you as being someone who may be suitable for this study. You have experienced more than one episode of psychosis and are on the NHS Lothian patient caseload.

Do I have to take part ?

No. This study is voluntary. It is your choice if you want to take part in this study. You can read through this information and talk to me. If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time from this study without giving a reason. This *will not* affect the standard of care or any treatment that you receive.

If you think that you would like to take part in this study, please read on. This leaflet will describe what is involved in taking part, and answer some basic questions. If you have more questions, my contact details are attached and I will be glad to answer them.

If you decide you would like to participate in this research, please let your CPN, Keyworker or Consultant Psychiatrist know. Alternatively, you can contact me or email at chrissie.johnson@nhslothian.scot.nhs.uk or leave a message with the secretary on the following numbers Tel: 0131 537 6905 or 0131 537 6723.

What will I have to do if I take part ?

The first part of the research is an interview. The interview could either take place at NHS premises or at your home if this was possible. I will be interviewing you, but you would be welcome to have a staff member or a friend with you if you preferred. I expect that the interview will take about 1-1 ½ hours, but it could be shorter or longer than this, depending on how much you wanted to say.

The exact questions I ask you will depend on your experiences. However, I can give you an idea of the type of question I may ask, for example:

- *Can you tell me about who you would tend to turn to if you felt you needed some support in your life ?*
- *Can you tell me about a time when you have found it useful to seek help from other people ?*
- *Can you tell me about a time when you have not found it helpful to seek help from other people ?*

The interview will be recorded using a digital audio recorder. I will also take notes during the interview. You will also be given the choice to have a typed copy of your interview if you wish, and you will be able to review this before agreeing to your interview data being used for the research.

The second part of this research requires you to complete four short questionnaires. I am doing this with everyone who takes part in the research. The questionnaires help me to better understand your views and attitudes on a number of things such as relationships, services and your own personal experiences with psychosis. This will provide me with additional helpful information to help me understand each person's experiences in greater context.

I expect that it will take approximately 20-30 minutes to complete these questionnaires. I can leave you to complete these questionnaires by yourself, or you can ask me to go through these with you if you prefer. The first questionnaire explores your style of relating to other people by asking you to choose which of four statements best describes how you approach relationships. The next questionnaire looks at how you view your experience of being unwell by asking you to agree or disagree with a series of 39 statements. The third questionnaire asks you about your current relationship with services, getting you to rate how closely each of 25 statements represents your own personal experience with a service. The final questionnaire assesses the type of thoughts or beliefs you have about your mental health by rating 29 statements from 'strongly disagree' to 'strongly agree'.

What are the disadvantages and risks of taking part ?

The study will take approximately 2 hours of your time in total. Taking part would involve taking time to meet with me, and the cost of travelling to a local venue where we can carry out the interview. However, wherever possible I would try and meet you at a convenient place. It is possible that the interview may cover some past experiences which are upsetting for you. Should this happen, you are free to discontinue, and may leave at any time.

What are the possible benefits of taking part ?

I cannot promise the study will help you, but the information that we get from this study may help improve understanding of the effect that psychosis has on people and their ability to seek help. Many people experience participation in research as a positive experience.

Is this ‘therapy’?

No. These interviews are for research purposes only. They are not connected to any treatment on the ward or in the community. Although I am interested to hear about your experiences, I will not be able to offer you any personal advice or therapy during this research. If you do feel that you need further support, I would be happy to discuss this with you and your staff team separately.

What will you do with the information I give you?

I will be carrying out a number of interviews with other people. I will look at the similarities and differences between people’s experiences of help seeking. The results will be written up as part of a doctoral thesis for submission to the University of Edinburgh Doctorate in Clinical Psychology course. They may also be submitted for publication in a peer reviewed journal. You will not be identified in any report or publication. Any quotes from interviews will be given under an assigned false name.

Will my taking part in the study be kept confidential ?

I will follow ethical and legal practice for this research, and all information about you will be handled in confidence. However, the usual limits to confidentiality apply. For example, if you told me something which places you or someone else at risk of harm I would have to pass this information on to your immediate care team. However, I would always try to discuss this with you if this was the case.

With the exception of the consent form, all the information you give me will be recorded using a false name to preserve your anonymity. The consent form with your real name will be stored securely in the Psychology premises. All other information will only have your false name on them. When your interviews are typed, any identifying information (e.g. your name, friend’s names, place of work etc.) will be changed or deleted, and the audio data will be destroyed within a month of completion of the academic project.

What if there is a problem ?

If you have any general concerns or queries about taking part in research and you would rather talk to somebody independent of this research project, please call Dr Richard Cosway, Clinical Psychologist on 0131 537 6571 or email: Richard.J.Cosway@nhslothian.scot.nhs.uk

Any complaint about the way you have been dealt with during the course of the study will be treated seriously. If you have any concerns about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions (Tel: 0131 537 6905). If you remain unhappy and wish to complain formally, you can do this via the NHS complaints procedure. Details can be obtained from: NHS Lothian Complaints Team, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh EH1 3EG Telephone: 0131 536 3370. Email: complaints.team@nhslothian.scot.nhs.uk

Who is sponsoring the research ?

The research is being sponsored by the University of Edinburgh, Clinical Psychology Department, School of Health in Social Science and NHS Lothian.

Who has reviewed the study ?

All NHS research is reviewed by an independent group of people called a Research Ethics Committee, to ensure your interests are protected. This study has been reviewed and approved by the West of Scotland Research Ethics Committee (1). The approach used in this study has also been reviewed and approved by the Department of Clinical Psychology Research Committee at the University of Edinburgh.

Many thanks for reading this leaflet. If you would like to participate in the research, or would like more information, please inform your consultant psychiatrist or keyworker, or contact me using the details below. Thank you.

Chrissie Johnson
Psychology Department
Royal Edinburgh Hospital
Morningside Terrace
Edinburgh
Tel: 0131 5376905
Email: chrissie.johnson@nhslothian.scot.nhs.uk

Appendix F: Participant Consent Form



Help seeking and psychosis: an exploration.

PARTICIPANT CONSENT FORM

**Please initial
box if agree**

1. I confirm that I have read and understood the information sheet for this study dated.....and have had the opportunity to ask questions. ☐
2. I understand that my participation in this study is voluntary and that I am free to withdraw at any time without giving a reason, without my care or legal rights being affected. ☐
3. I understand that the researcher and direct members of the research team may look at relevant sections of my medical records in order to confirm details such as my date of birth, diagnosis and past history of admissions. I give permission for these individual to have access to this information. ☐
4. I consent to audio recording of the interview and understand that any transcripts made from this will be anonymised, the recording stored securely and destroyed on completion of the project. ☐
5. I understand that relevant data collected during the study may be looked at by individuals from the University of Edinburgh, from regulatory authorities and the NHS Trust. I give permission for these individuals to have view of my data. ☐
6. I understand that if there are concerns about a risk of harm to myself or others during my participant, the researcher will assess the risk and take appropriate action. This may involve contacting other professionals, including my GP, in order to communication information relevant to concerns about risk of harm. ☐
7. You may contact my GP and/or consultant psychiatrist and/or Community Psychiatric Nurse to inform them that I am taking part in this study. ☐
8. I agree to take part in the above study. ☐
9. I would like the researcher to send me information about the findings from this research. YES/ NO
(delete as applicable)

Name of participant: _____ Date: _____ Signature: _____

Name of person: _____ Date: _____ Signature: _____
taking consent

Appendix G : Interview guide

Help seeking and psychosis: an exploration.

(NB: Questions have been designed to elicit the participant's specific experience in relation to the research topic and this interview guide will be used as a tool to prompt further exploration if needed. *Therefore, it is not envisaged that every question will be asked of every participant, nor that this is a comprehensive list of all the questions that may be asked during the interview.*)

Intro:

I would like to talk to you about some of your experiences in seeking help and support, both in your current life, and in the past. I am interested in your experiences with seeking help for mental health difficulties, but also how you seek help in other areas of your life.

Initial Open Questions

- Could you tell me about the people who currently offer you support in your life? What type of support do each of these people offer you?
- How have you found your experience of getting help from other people? Is there anything you have found difficult about this experience? (Expand)
- How do you recognise when you need help with something? Are there any things that you find it easier to ask help with? What sorts of things are difficult for you to ask for help with? (Expand)

Intermediate Questions (*Help seeking in mental health services*):

- Can you tell me about the events that first brought you into contact with rehabilitation services? Who was the most helpful to you during this time? In what way were they helpful? Who was most unhelpful to you during this time? In what way were they unhelpful?
- Can you tell me about the events leading up to your most recent admission? Were there any ways in which this was different from your previous experiences in hospital? Was there anything that you found more helpful during this most recent admission, compared to previous times in hospital? Was there anything that you found less helpful than in the past?
- Have your relationships with mental health services and staff changed over time? In what way? What do you feel is the reason for this?
- Who are the people that you remember the most during your contact with mental health services (this can be positive memories or negative memories)? Why was this person so memorable for you? How would you describe your relationship with this person?

Help seeking in a developmental context:

- When you were a child, who did you turn to for help? In what way were they able to help you? How useful did you find this?

Ending questions

- How, if at all, have your feelings changed about seeking help and support over time?
- In what areas of your life do you feel you may need the most / least help in future? Where would you go for help with this?
- How comfortable would you feel looking for help in future? In what way is this different from the past (if not already explored)?

Closing the interview

Thank you. We have come to the end of the interview. Before we finish, is there anything you think I should know that you have not had chance to tell me about? Is there anything you would like to ask me?

Appendix H: Examples of Qualitative Analysis Process

i. Transcript line by line (or segment) coding.

<i>Being excluded from decision</i>
<i>Having no environmental stability</i>
<i>Feeling in 'altered state of mind' (losing touch with reality ?)</i>
<i>Becoming confused and having disturbed sleep</i>
<i>Being taken by surprise</i>
<i>Losing 'right to know' - being 'deceived' (the meaning of parents excluding him from decision...losing trust ?seeing him differently ?)</i>
<i>Attempting to place parent's behaviour in trait context.</i>
<i>Losing involvement / status ?</i>
<i>Being coerced into 'help receiving'. Feeling shocked</i>

[*P*]: I felt that my parents had made the decision. I remember we were down..it was before they had bought a house..we were down staying with my mum's parents in [place name] and I remember erm feeling like I was in an altered state of mind. I wasn't sleeping well and I was kind of feeling confused and stuff. Erm ..I remember one day they erm they said come on get in the car and I was like 'what's all this about ?' and they didn't say where we were going. And erm I got in the car anyway a bit reluctant, and we ended up at the Royal Edinburgh Hospital which I feel was rather err somehow its typical of my parents that they kind of.. surprise you with something like that. There was no case of er a doctor being called or some kind of official kind er introductions given before I was in the hospital, it was just kind of like I was taken.

ii. Raising line by line codes into initial focused coding

<u>Phil P01</u>	
Initial focused coding	Line by line coding (or segment)
Relating within the mental health system	Attempting to understand the unspoken interpersonal relationships and rules within the system
	Breaking the rules...finding out where the power really lies
	Recognising the 'artificial nature' of reactions with professionals following rupture
	Managing the multilayered relationships with professionals - overt and covert feelings, responses and thoughts.
	Dealing with the emergence of power structures during rupture
	Becoming aware of the closed nature of the system 'small world'
	Worrying about attracting a reputation 'what goes around comes around'
	Recognising the divide between staff working at the hospital (they get in their car at night and switch on the radio) and self

Appendix H (cont.):

iii. Use of post-it note boards to develop conceptual categories



iv) Example of NVivo10 Transcript Category Coding

Mixed methods final coding 050713.nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Navigation View Find Quick Coding Workspace Dock All Undock All Close All Detail View List View Coding Stripes Highlight Links Framework Matrix Classification Report Previous Next Color Scheme Visualization

Sources

Look for: Search In: Internals Find Now Clear Advanced Find

Internals

Name	Nodes	References	Created On	Created By	Modified On	Modified By
P08 Matthew	11	55	05/07/2013 11:05	CPG	05/07/2013 11:05	CPG



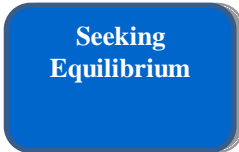
P: You never know with the internet you might be able to track people down...

P: Saving my money and ask a private detective...but I think that would be more intrusive than saying Steve wants to say you. But err I know I'd be more than welcome with my friends more than welcome cos I haven't seen them for 20 years. I was doing a Masters degree...at the school of tropical medicine and I used it to go to India with a leprosy colony with mother Theresa. I found that fascinating and very interesting. I would like to go back to India, there's a calling for me to go back to India. I just comply with everything...I take the injection and it means nothing to me cos I still hear the voices, the injections doing nothing for me whatsoever you know but I just find that err I can only take it one day at a time. I have I have plans I like to read my books and erm my music, classic FM I like to listen to the radio programme, but err...my wants are few, my needs are few. I need space and sometimes I can't get it on the ward when people are high. And just sometimes I think they just look at Matt and not a cool guy I don't think they would think I was a cool guy but I don't give them much problems. I've been told I'm a gentleman, take it anyway you like but...I don't give the staff problems...and the rest is...when the patients give the staff problems its hard for me to talk to staff.

R: That's great - thank you so much you've given me a lot of interview there.

CPG 9 Items Nodes: 11 References: 55 Read-Only Line: 517 Column: 0 100% 09:09 25/07/2013

Appendix I: Hypothesised barriers and facilitators to help-seeking and service engagement by process stage.

Process Stage	Possible Barriers	Potential Facilitators
 <p>Becoming Involved with Services</p>	<ul style="list-style-type: none"> • Loss of frame of reference to explain inner experience (first onset and relapse) • Lack of knowledge of pathways for help-seeking (first onset) • Fear of implications of experience (first onset and relapse) • Difficulty effectively communicating inner experience to others (first onset and relapse) • Ineffective previous requests for help (first onset) • Fear of repeated past experience (relapse) • View of others/ world as threatening (first onset and relapse) • Shock of entry (loss of status / control) • Rupture of existing support relationships 	<ul style="list-style-type: none"> • Formation of a strong professional relationship prior to increased intensity of service involvement (first onset and relapse) • Increased sense of threat in external environment vs. service environment (first onset and relapse) • Increased sense of control / involvement in decision (first onset and relapse)
 <p>Negotiating Relationships</p>	<ul style="list-style-type: none"> • Uncertainty regarding inner vs. external 'reality' • Difficulty expressing inner experience. • Poor (perceived) understanding from others. • Lack of inner template for service relationships • Previous negative experiences (e.g. making complaints, misunderstanding boundaries, encountering service limitations). • Fears of negative judgement (being a 'burden', rejected, perceived as 'unwell') and consequences (loss of status, prolonged treatment). • Perceived mismatch in relationship investment ('just a job to them'). • Internal belief of others as unhelpful / uncaring. • Uncertainty / denial about need for help (distorted 'mirror') 	<ul style="list-style-type: none"> • Capacity to find shared territory for understanding internal experience (emotional reassurance, 'grounding' inner experience, mirror for wellness). • Acknowledged sense of uncertainty about experiences. • Mutual importance given to personal, informal support (e.g. 'chat') as well as formal intervention. • Consistent experience of a contrasting, positive model of relating. • Sense of shared, non-judgemental exploration of 'boundary violations'. • Environmental supports.
 <p>Seeking Equilibrium</p>	<ul style="list-style-type: none"> • Incompatibility of service vs. individual beliefs regarding factors relating to relapse and recovery (e.g. facing emotions, physical welfare). 	<ul style="list-style-type: none"> • Ability for individual to establish a sense of control / rules for engagement. • Capacity to explore, accept or reconcile losses within services and help-seeking difficulties in past. • Service able to facilitate / support individual goals for (re)building identity.

Appendix J :Author submission guidelines to Psychology and Psychotherapy: Theory Research and Practice.

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via <http://www.editorialmanager.com/paptrap/>. The Journal operates a policy of anonymous peer review. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#).

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded [here](#).
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.
- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (<http://www.consort-statement.org>).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

6. Multiple or Linked submissions

Authors considering submitting two or more linked submissions should discuss this with the Editors in the first instance.

7. Supporting Information

PAPT is happy to accept articles with supporting information supplied for online only publication. This may include appendices, supplementary figures, sound files, videoclips etc. These will be posted on Wiley Online Library with the article. The print version will have a note indicating that extra material is available online. Please indicate clearly on submission which material is for online only publication. Please note that extra online only material is published as supplied by the author in the same file format and is not copyedited or typeset. Further information about this service can be found at <http://authorservices.wiley.com/bauthor/suppmat.asp>

8. Copyright and licenses

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services, where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions

http://authorservices.wiley.com/bauthor/faqs_copyright.asp

9. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded [here](#).

Appendix K : Summary of questionnaire scores with supporting graphical representations.

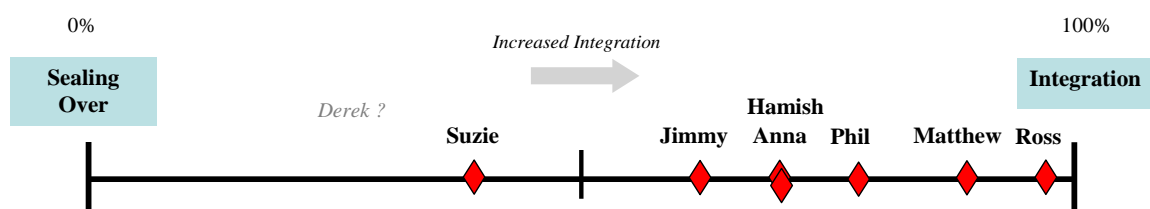
- **Participant Scores on the Recovery Style Questionnaire (RSQ; Drayton *et al.*, 1998).**

(High %, low global scale score = higher integration)

	Total (out of 13)	(%)	Global Scale Score (out of 6)	Style
Phil (P01)	10	77%	2	Tends towards integration
Geoff (P02)				n/c
Suzie (P03)	5	38%	4	Mixed picture - sealing over predominates
Derek (P04)				(Sealing over ?)
Ross (P05)	12	92%	1	Integration
Anna (P06)	9	69%	2	Tends towards integration
Jimmy (P07)	8	62%	3	Mixed picture - integration dominates
Matthew (P08)	11	85%	1	Integration
Hamish (P09)	9	69%	2	Tends towards integration

NB: n/c= not completed. Derek completed 19 out of 39 questions on the scale, 14 of which represented a sealing over style of response.

- **Graphical representation of relative degree of integration (RSQ) reported by participants.**



Appendix K (cont).

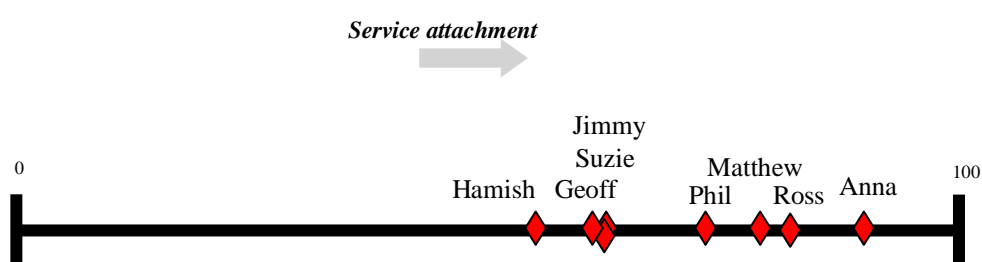
- **Participant scores on the Service Attachment Questionnaire (SAQ; Goodwin *et al.*, 2003).**

High score = higher engagement

	Listening (max.16)	Consistency (max.16)	Ending (max.20)	Safety (max.16)	Talking (max.16)	Comfort (max.16)	Total (max 100)
Phil (P01)	13	9.67	13.75	11	12	13	72.42^a
Geoff (P02)	13	10.67	n/c	14.67	10	12	60.34^a
Suzie (P03)	11	10	13	9	8	11	62
Derek (P04)							n/c ^b
Ross (P05)	14	13	15	13	12	13	80
Anna (P06)	15	14	16	12	15	16	88
Jimmy (P07)	10	7.5	12.5	10	10	12	62
Matthew (P08)	12	13	14	12	13	14	78
Hamish (P09)	12	10	7	11	5	8	53

^a Subscale scores in italics pro-rated or missing as felt unwilling to complete questions regarding service discharge as 'I am already discharged'. ^b n/c = not completed ("I do not have problems and I don't want help").

- **Graphical representation of relative strength of service attachment (SAQ)**



Appendix K (cont).

- Summary of participant scores on the RQ (Bartholomew & Horowitz, 1991)

	Secure	Fearful	Preoccupied	Dismissing	Model of Self	Model of Other
Phil (P01)	3	7	5	4	-5	-3
Geoff (P02)	6	5	7	4	-2	4
Suzie (P03)	5	3	4	6	4	0
Derek (P04)	n/c	n/c	n/c	n/c	n/c	n/c
Ross (P05)	7	6	2	6	5	3
Anna (P06)	7	1	1	1	6	6
Jimmy (P07)	3	7	6	5	-5	-3
Matthew (P08)	7	2	1	2	6	4
Hamish (P09)	2.5	5	6	7	-1	-3

NB: n/c = not completed (“don’t capture how I feel; I don’t have close relationships”);
‘Model of Self’ = (Secure + Dismissing) - (Fearful + Preoccupied); ‘Model of Other’ =
(Secure + Preoccupied) – (Dismissing + Fearful).

Secure = Low dependency/ Low avoidance; Preoccupied = High dependency/ Low avoidance; Avoid-Dis = Low dep/High avoid; Avoid-Fear = High dep/High avoid.

- Participant scores on the PBIQ-R (Birchwood *et al.* 2012).

	Control (max. 30; high score = low control)	Shame (max.36; high score = high shame)	Entrapment (max. 36; high score = high entrap.)	Loss (max. 43; high score = high loss)	Social Marginalisation (max. 30; high score = high marg.)
Phil (P01)	11	16	17	17	13
Geoff (P02)	n/c				
Suzie (P03)	11	17	14	18	11
Derek (P04)	n/c				
Ross (P05)	14	15	17	14	11
Anna (P06)	12	8	14	19	6
Jimmy (P07)	15	13	18	14	14
Matthew (P08)	15	16	19	19	12
Hamish (P09)	17	16	21	23	16

Appendix L: Additional Participant Information

(sourced from medical records where information available)

<i>Participant Reference</i>		<i>Age at first contact with psychiatric services (years)</i>	<i>Reasons for first contact</i>	<i>Age at first admission where available (years)</i>	<i>Reasons for first admission</i>
P01	<i>Phil</i>	17	Drug Use (A & E admission)	19	-
P02	<i>Geoff</i>	13	-	-	-
P03	<i>Suzie</i>	25	Eating disorder	-	Overdose
P04	<i>Derek</i>	21	Health Anxiety / Identity Issues	26	‘Strange behaviour’
P05	<i>Ross</i>	18	GP concerns re: psychosis	22	-
P06	<i>Anna</i>	23	Anxiety, mood, sleep & eating	-	-
P07	<i>Jimmy</i>	19	‘Disturbed behaviour’	22	-
P08	<i>Matthew</i>	40	Trauma (?)	40	‘Threatening behaviour’
P09	<i>Hamish</i>	19	-	22	-

Appendix M: Overview of participant's relative contribution to coding category (% coverage of category)

	Phil (P01)	Geoff (P02)	Suzie (P03)	Derek (P04)	Ross (P05)	Anna (P06)	Jimmy (P07)	Matthew (P08)	Hamish (P09)
<u>Becoming Enmeshed</u>									
<i>Losing Connection</i>	12.08%	2.68%			6.84%	9.67%	1.35%	1.82%	4.86%
<i>Changing Status</i>	9.06%	7.99%		1.49%	3.06%	0.65%	10.22%	6.02%	3.02%
<u>Negotiating Relationships</u>									
<i>Bridging Worlds</i>	3.95%		1.06%	14.17%	10.74%	9.22%	2.77%	2.97%	22.54%
<i>Making Sense</i>	12.90%	3.06%	11.90%		8.04%	1.97%	15.14%	6.46%	7.86%
<i>Seeking Help Beyond Service Relationships</i>		4.49%	8.23%	23.53%	1.11%	2.48%		2.58%	19.21%
<i>Protecting Self</i>	3.64%	5.44%	15.32%	1.13%	4.43%	1.39%	13.98%	12.32%	
<i>Ambivalence and Switching</i>	1.39%		6.29%	8.87%	3.69%	1.11%	0.56%	3.29%	
<u>Seeking Equilibrium</u>									
<i>Defending Against Destabilisation</i>	3.38%				10.73%	8.21%		3.87%	2.34%
<i>Restoring Individuality</i>	4.73%	2.00%	2.04%		6.00%	4.02%	6.67%	14.52%	4.85%
<i>Assimilation and Reconciliation</i>	24.02%	3.36%	2.50%	8.39%	4.63%	0.82%	3.35%	22.17%	2.41%
<i>Defining Terms of Acceptance</i>	9.45%	4.22%	0.63%	7.95%	5.00%	6.88%	16.23%	4.23%	

NB:

1. Blank squares denote participant did not contribute to coding category. Contribution to category does not reflect nature of participant experience.
2. % coverage is given as a rough guide to participant contribution to category for comparison purposes only. The remaining proportion of the transcript refers to interviewer dialogue or elements accepted as falling outside the scope of the focus of the analysis.